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1.0 Description of the Procedure, Product, or Service

1.1 Definitions

The North Carolina Innovations Waiver Services (NC Innovations) is a resource for funding services and supports for Medicaid beneficiaries with intellectual and other related developmental disabilities who are at risk for institutional care in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID). NC Innovations is authorized by a Medicaid Home and Community-Based Services (HCBS) Waiver granted by the Centers for Medicare and Medicaid Services (CMS) under Section 1915 (c) of the Social Security Act. This current waiver was renewed and approved to be effective, August 1, 2013 for five years. It operates concurrently with a 1915 (b) Waiver, the North Carolina Mental Health/Developmental Disabilities/ Substance Abuse Services Health Plan (NC MH/DD/SAS Health Plan). The NC MH/DD/SAS Health Plan functions as a Prepaid Inpatient Health Plan (PIHP) through which all mental health, substance abuse and intellectual/developmental disabilities services are authorized for Medicaid enrollees. Local Management Entities (LMEs) are area authorities in the State of NC which are responsible for certain management and oversight activities with respect to publically funded DMH/DD/SAS services and are PIHPs for the waiver.

CMS approves the services provided under NC Innovations, the number of beneficiaries that may participate each year, and other aspects of the program. The waiver can be amended with the approval of CMS. CMS may exercise its authority to terminate the waiver whenever it believes the waiver is not operated properly.

The Division of Medical Assistance (DMA), the NC Medicaid agency, operates the NC Innovations Wavier. DMA contracts with the PIHP to arrange for, manage the delivery of services, and perform other waiver operational functions under the concurrent 1915 (b) (c) waivers. DMA directly oversees the NC Innovations Waiver, approves all policies and procedures governing waiver operations and ensures that the NC Innovations Waiver assurances are met.

The requirements for administration of NC Innovations include lists of target populations, waived Medicaid requirements, services, and beneficiaries; they also specify the duration of the waiver. The following regulations give the North Carolina Department of Health and Human Services (DHHS) the authority to set the requirements included in this policy:

- a. Federal Regulations for HCBS waivers are found in 42 CFR 441G.
- b. Section 1915(c) of the Social Security Act authorizes the Secretary of Health and Human Services to waive certain specific Medicaid statutory requirements so that a state may offer HCBS to state-specified target groups of Medicaid beneficiaries who need a level of institutional care that is provided under the Medicaid State Plan.

- c. Section 1902(a)(10)(B) of the Social Security Act provides that Medicaid services shall be available to all categorically eligible individuals on a comparable basis. This HCBS waiver targets services only to the specified group of beneficiaries that meet the level of care established for an ICF-IID; and includes services that are not otherwise available under the State plan; and offers services that are not available to beneficiaries who do not participate in the waiver. Thus, the waiver of 1902(a)(10)(B) is an integral feature of the program.

Refer to **Attachment C** for service definitions and **Attachment A**, HCPCS Codes, for services which are billable under the waiver.

2.0 Eligibility Requirements

2.1 Provisions

2.1.1 General

(The term “General” found throughout this policy applies to all Medicaid and NCHC policies)

- a. An eligible beneficiary shall be enrolled in either:
 1. the NC Medicaid Program (*Medicaid is NC Medicaid program, unless context clearly indicates otherwise*); or
 2. the NC Health Choice (*NCHC is NC Health Choice program, unless context clearly indicates otherwise*) Program on the date of service and shall meet the criteria in **Section 3.0 of this policy**.
- b. Provider(s) shall verify each Medicaid or NCHC beneficiary’s eligibility each time a service is rendered.
- c. The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for this service.
- d. Following is only one of the eligibility and other requirements for participation in the NCHC Program under GS 108A-70.21(a): Children must be between the ages of 6 through 18.

2.1.2 Specific

(The term “Specific” found throughout this policy only applies to this policy)

- a. **Medicaid**
None Apply.
- b. **NCHC**
NCHC beneficiaries are not eligible for North Carolina Innovations.

2.2 Special Provisions

2.2.1 EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age

- a. **42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]**

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary under 21 years of age **if** the service is **medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a condition [health

problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner).

This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product or procedure:

1. that is unsafe, ineffective, or experimental or investigational.
2. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

b. EPSDT and Prior Approval Requirements

1. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does **NOT** eliminate the requirement for prior approval.
2. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *NCTracks Provider Claims and Billing Assistance Guide*, and on the EPSDT provider page. The Web addresses are specified below.

NCTracks Provider Claims and Billing Assistance Guide:

<https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html>

EPSDT provider page: <http://www.ncdhhs.gov/dma/epsdt/>

2.2.2 EPSDT does not apply to NCHC beneficiaries

2.2.3 Health Choice Special Provision for a Health Choice Beneficiary age 6 through 18 years of age

The Division of Medical Assistance (DMA) shall deny the claim for coverage for an NCHC beneficiary who does not meet the criteria within **Section 3.0** of this policy. Only services included under the NCHC State Plan and the DMA clinical coverage policies, service definitions, or billing codes are covered for an NCHC beneficiary.

2.3 Eligible Coverage Groups

Upon approval of ICF-IID level of care, Medicaid beneficiaries in the following coverage groups may receive NC Innovations:

- a. Medicaid to the Aged (M-AA)
- b. Medicaid to the Blind (M-AB)
- c. Medicaid to the Disabled (M-AD)
- d. Health Coverage for Workers with Disabilities (HCWD) Basic Group
- e. IV-E Adoption Assistance and Foster Care (I-AS) 42. CFR 435.115(e)(2)
- f. State Foster Care (H-SF)
- g. State/County Special Assistance to the Aged (S-AA)
- h. State/County Special Assistance to the Disabled (S-AD)

Note: As not all Medicaid beneficiaries are eligible for NC Innovations (refer to **Subsection 3.2**, Medicaid Additional Criteria Covered, below), care coordinators shall contact the department of social services (DSS) in the county in which the beneficiary lives when considering a new applicant for NC Innovations.

2.4 Coordination of the Waiver and Regular Medicaid Services

NC Innovations operates concurrently with the NC MH/DD/SAS Health Plan. The NC MH/DD/SAS Health Plan includes State Medicaid Plan services for behavioral health services as well as inpatient psychiatric and ICF-IID. Approval of the NC Innovations Individual Support Plan does NOT replace the prior approval requirements or other eligibility requirements for services in the State Medicaid Plan, which are outside of the NC MH/DD/SAS Health Plan, i.e. private duty nursing, physical therapy, occupational therapy, speech therapy, etc. These services are not part of the NC Innovations Waiver or NC MH/DD/SAS Health Plan and are accessed through the regular State Medicaid Program according to Medicaid policies and procedures.

3.0 When the Procedure, Product, or Service Is Covered

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

3.1 General Criteria Covered

Medicaid or NCHC shall cover procedures, products, and services related to this policy when they are medically necessary, and:

- a. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the beneficiary's needs;

- b. the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and
- c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the beneficiary, the beneficiary's caretaker, or the provider.

3.2 Specific Criteria Covered

3.2.1 Specific criteria covered by both Medicaid and NCHC

None Apply.

3.2.2 Medicaid Additional Criteria Covered

NC Innovations services shall be covered for a Medicaid beneficiary with intellectual or developmental disabilities, or both, who meets **all** of the following criteria:

- a. Requirements for ICF-IID level of care;
- b. Resides in an ICF-IID facility or is at high risk of being placed in an ICF-IID facility;
- c. Able to maintain his or her health, safety, and well-being in the community with NC Innovations services;
- d. Requires NC Innovations services as identified through a person-centered planning process. The beneficiary shall require at least one waiver service provided monthly as identified in the person-centered planning process and indicated in the Individualized Support Plan (ISP) and Individualized Budget; and
- e. Alone or with his or her family or legal guardian, the beneficiary desires NC Innovations participation rather than institutional services.

3.2.3 NCHC Additional Criteria Covered

None Apply.

4.0 When the Procedure, Product, or Service Is Not Covered

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

4.1 General Criteria Not Covered

Medicaid or NCHC shall not cover procedures, products, and services related to this policy when:

- a. the beneficiary does not meet the eligibility requirements listed in **Section 2.0**;
- b. the beneficiary does not meet the criteria listed in **Section 3.0**;
- c. the procedure, product, or service duplicates another provider's procedure, product, or service; or
- d. the procedure, product, or service is experimental, investigational, or part of a clinical trial.

4.2 Specific Criteria Not Covered

4.2.1 Specific Criteria Not Covered by both Medicaid and NCHC

None Apply.

4.2.2 Medicaid Additional Criteria Not Covered

None Apply.

4.2.3 NCHC Additional Criteria Not Covered

- a. NCGS § 108A-70.21(b) “Except as otherwise provided for eligibility, fees, deductibles, copayments, and other cost sharing charges, health benefits coverage provided to children eligible under the Program shall be equivalent to coverage provided for dependents under North Carolina Medicaid Program except for the following:
 1. No services for long-term care.
 2. No nonemergency medical transportation.
 3. No EPSDT.
 4. Dental services shall be provided on a restricted basis in accordance with criteria adopted by the Department to implement this subsection.”

5.0 Requirements for and Limitations on Coverage

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

5.1 Prior Approval

The provider(s) shall obtain prior approval before rendering NC Innovations services for Medicaid beneficiaries.

5.2 Prior Approval Requirements

5.2.1 General

The provider(s) shall submit to the Department of Health and Human Services (DHHS) Utilization Review Contractor the following:

- a. the prior approval request;
- b. all health records and any other records that support the beneficiary has met the specific criteria in **Subsection 3.2** of this policy.

5.2.2 Specific

NC Innovations Waiver services require Prior Approval by the PIHP. The PIHP approves the ISP and may approve or reduce or deny individual services. All NC Innovations service beneficiaries shall have an approved plan annually to continue participation in the waiver.

5.3 Plan of Care

5.3.1 Oversight of Plan of Care Approval Process

Oversight of the process is provided by DMA. DMA authorizes the PIHP to approve Individual Support Plans (ISPs) and routinely monitors the ISP Approval Process. DMA may revoke approval authority if it determines that the PIHP is not in compliance with the waiver requirements. In the case of a revocation, the ISP approval would be carried out by DMA or a DMA designee. The ISP approval authorization process verifies that there is a proper match between the beneficiary need and the service provided. This involves identification of over-utilized and under-utilized services through careful

analysis of the beneficiary's needs, problems, skills, resources and progress toward the beneficiary's life plan.

5.3.2 ISP Approval and Service Authorization Process

If the beneficiary or legal guardian accepts the plan and the plan appears to meet NC Innovations criteria, the ISP or revision to the ISP and other required information are submitted to the PIHP. Approval of the ISP or revisions to the ISP occurs locally at the PIHP following a process approved by DMA.

5.3.3 ISP Disapproval

If the PIHP does not approve the ISP, the PIHP notifies the beneficiary or legal guardian in writing of the denial and the beneficiary's appeal rights. The PIHP notifies the DSS Income Maintenance staff of the denial once all appeals processes have been exhausted.

If an ISP is not submitted with an authorized signature (beneficiary or legal guardian) by the expiration of the beneficiary's current ISP, the beneficiary becomes ineligible for continued NC Innovations services. The PIHP terminates the beneficiary from NC Innovations and issues appeal rights to the beneficiary or legal guardian. DSS is notified and may terminate the beneficiary from Medicaid if the individual's Medicaid eligibility is contingent upon NC Innovations waiver participation. If the beneficiary wishes to re-enter the waiver in the same waiver year, the procedures for a new waiver beneficiary's entry into NC Innovations are followed, including obtaining a new level of care. The waiver year begins August 1 and runs to July 31 of the following year.

PIHP Individual Support Plan approval staff has extensive expertise in practices and interventions in the field of developmental disabilities. They are trained in the use of clinical practice guidelines developed by the PIHP, person-centered planning, risk planning, level of care determination, assessment, best practice in developmental disabilities, and the requirements of the waiver. Their primary function is to make plan of care approval and authorization decisions by conducting initial, continuing, discharge and retrospective authorizations of services. The work is accomplished through the consistent and uniform application of the PIHP's clinical criteria to each beneficiary's needs to determine the appropriate type of care, in the appropriate clinical setting.

5.3.4 ISP Approval Requirements

The minimum information required for Individual Support Plan approval is:

- a. **Initial ISP Review:** Contact information for the care coordinator ; Individual Support Plan, including the Freedom of Choice Statement; Individual Budget; Initial Level of Care assessment and the supporting evaluations, as applicable; the Risk/Support Needs Assessment; the Supports Intensity Scale ® (SIS) or the NC SNAP; additional assessments; Behavior Support Plan, if available and needed physician orders.
- b. **Annual ISP Review:** Contact information for the ; Individual Support Plan, including Freedom of Choice Statement and the annual reassessment of the Level of Care; Individual Budget; the Risk/Support Needs Assessment; the

Supports Intensity Scale ®(SIS) or the NC SNAP; additional assessments, as applicable; Behavior Support Plan, if available and needed physician orders. For Annual ISPs, the PIHP completes the final determination for the continued authorization of Level of Care. If the PIHP questions the need for continued ICF-IID level of care, the process for completing an initial Level of Care is followed and needs to be initiated.

- c. **Revisions:** Contact information for the care coordinator; the completed update page of the Individual Support Plan; and the revised Individual Budget; and if needed, evaluations to support requested services, inclusive of physician orders.

5.3.5 Assistive Technology, Equipment, Supplies, Home Modifications and Vehicle Adaptations

For requests for assistive technology equipment and supplies home modifications, and vehicle adaptations, the following additional information is required:

- a. a plan for how the beneficiary and family will be trained on the use of the equipment;
- b. statement of medical necessity by a physician (not required for repair);
- c. shipping costs must be itemized in the request to be included;
- d. other information as required for the specific equipment or supply request;
- e. when a written recommendation is required by an appropriate professional and a physician's signature certifying medical necessity, the PIHP determines if the physician's signature must be included on the recommendation or if it may be on a separate document;
- f. the PIHP determines the appropriate professional(s) that make written recommendations for services that require those recommendations; and
- g. when quotes are required for purchases, the PIHP determines how many are required.

For requests for assistive technology equipment and supplies, the following additional information is required:

- a. An assessment or recommendation by an appropriate professional that identifies the beneficiary's need(s) with regard to the equipment and supplies being requested. The assessment or recommendation must state the amount of an item that a beneficiary needs.
- b. Supplies that continue to be needed at the time of the beneficiary's Annual Plan must be recommended by an annual re-assessment by an appropriate professional. The assessment or recommendation must be updated if the amount of the item the beneficiary needs changes.

For requests for adaptive car seats, the following additional information is required:

- a. Beneficiaries shall have a documented chronic health condition of developmental disability which requires the use of an adaptive car seat for positioning. Car seats will not be approved for behavioral restraint.
- b. Providers shall request prior approval with the following information in the assessment:
 - 1. Beneficiary's weight;
 - 2. Weight limits of the car seat currently used to transport;

3. Beneficiary has a seat to crown height that is longer than the back height of the largest child car safety seat if the beneficiary weighs less than the upper weight limit of the current car seat. The measurements must be documented;
4. Reasons why the beneficiary cannot be safely transported in a car seat belt or convertible or booster seat for individual weighing 30 pounds and up; and
5. Certification of medical necessity, assessment requirements and price quotes as required by PIHP policy and NC Innovations Technical Guide <http://www.ncdhhs.gov/dma/lme/MHWaiver.htm>.

For Community Transition, the following additional information is required:

- a. A Community Transition Checklist.

For Home Modifications, the following additional information is required:

- a. Assessment/recommendation by an appropriate professional that identifies the beneficiary's need(s) with regard to home modifications requested.

For In-Home Intensive Supports, the following information is required:

- a. Assessment, and if indicated, a fading plan or plan for obtaining assistive technology to reduce the amount of In-Home Intensive Supports needed by the beneficiary.

For Vehicle Adaptations, the following additional information is required:

- a. A recommendation by a physical therapist/occupational therapist specializing in vehicle modification or a rehabilitation engineer or vehicle adaptation.
- b. The recommendation must contain information regarding the rationale for the selected modification, beneficiary, and pre-driving assessment of the beneficiary will be driving the vehicle, condition of the vehicle to be modified, and the insurance on the vehicle to be modified. The responsibility of the family keeping their insurance current is between the Department of Motor Vehicles (DMV) and the family.
- c. If purchasing a vehicle with a lift on it, the price of the used lift on the used vehicle must be assessed and the current value (not the replacement value) may be approved under this service definition to cover this part of the purchase price. In such instances, the beneficiary or family may not take possession of the lift prior to approval by the PIHP Utilization Management Department.
- d. Evaluation by an adapted vehicle supplier with an emphasis on safety and "life expectancy" of the vehicle in relationship to the modifications.
- e. The modification must meet applicable standards and safety codes. Care coordinators should inspect the completed adaptation from a health and safety perspective.
- f. If paying for labor and costs of moving devices or equipment from one vehicle to another vehicle, then training on the use of the device is not used.

For Natural Supports Education, the following additional information is required:

- a. Long range outcomes directly related to the needs of the Beneficiary or natural support's ability to provide care and support to the Beneficiary is required.

For Individual or Family Directed Supports, the following additional information is required:

- a. An Individual or Family Directed Supports Assessment;
- b. Representative Needs Assessment and Representative Designation or Agreement, as applicable;
- c. Verification of Training for Managing Employer and Representative, if applicable; and
- d. Individual and Family Directed Supports Agreement.

5.3.6 Timelines for ISP approval

Approval of Individual Support Plans will be completed in a timely manner. Review will be completed in 14 calendar days and result in **one** of the following actions:

- a. Plan approval and service authorization;
- b. Plan pended for up to 14 calendar days; or
- c. Denial of request.

5.3.7 Individual Support Plan Approval

If the PIHP approves the ISP, the PIHP issues service authorizations to the providers indicated in the ISP and gives written notification to the DSS Medicaid Staff of Initial ISP approval including a copy of the Individual Budget if the beneficiary had a deductible. Services, supplies and equipment must be prior authorized for payment. Following approval of the ISP, the PIHP:

- a. Gives the beneficiary or legal guardian written notification of the ISP approval, and a copy of the approved ISP, including the Individual Budget;
- b. Gives written notification to the DSS Medicaid staff of Annual ISP approval, including a copy of the Individual Budget, if the beneficiary has a deductible; and
- c. Ensures that the ISP is initiated and continues to monitor services.

Note: Services are expected to begin within 45 days following approval of the Initial ISP.

5.4 Additional Limitations or Requirements

A beneficiary may receive funding from only one HCBS Waiver at a time. If the beneficiary is transitioning from another waiver program to NC Innovations, it is critical that the PIHP works with the other waiver program to ensure that the transition to NC Innovations Waiver is coordinated.

6.0 Providers Eligible to Bill for the Procedure, Product, or Service

To be eligible to bill for the procedure, product, or service related to this policy, the provider(s) shall:

- a. meet Medicaid or NCHC qualifications for participation;
- b. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; and
- c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

6.1 Provider Qualifications and Occupational Licensing Entity Regulations

Some services distinguish between the professionals and paraprofessionals that may provide them. (Refer to **Attachment C, Service Definitions**, for service-specific requirements.)

Staff shall obtain licensure or certification according to N.C. General Statutes and practice within the scope of practice as defined by the individual practice board. The following types of staff are recognized:

- a. licensed professional counselor (LPC);
- b. licensed clinical supervisor (LCS);
- c. licensed clinical social worker;
- d. licensed psychologist;
- e. licensed psychological associate;
- f. certified clinical supervisor;
- g. registered nurse;
- h. licensed practical nurse;
- i. certified nursing assistant I;
- j. certified nursing assistant II;
- k. clinical nurse specialist;
- l. nurse practitioner;
- m. physician assistant;
- n. psychiatrist;
- o. qualified professional;
- p. paraprofessional;
- q. associate professional;
- r. board certified behavioral analyst;
- s. physical therapist;
- t. occupational therapist;
- u. recreation therapist; and
- v. certified assistive technology specialist.

6.2 Provider Certifications

Competencies of qualified professionals and associate professionals are documented along with supervision requirements to maintain that competency (10A NCAC 27G.0203).

Competencies and supervision of paraprofessionals are documented along with supervision requirements to maintain that competency (10A NCAC 27G .0204).

7.0 Additional Requirements

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

7.1 Compliance

Provider(s) shall comply with the following in effect at the time the service is rendered:

- a. All applicable agreements, federal, state and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and
- b. All of DMA's clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS and its divisions or its fiscal agent.

7.2 General Documentation Requirements

The minimum service documentation requirements for services provided through the NC Innovations Waiver are contained in this section and the *DMH/DD/SAS Records Management and Documentation Manual 45-2*. Information concerning documentation of all Medicaid or State funded services not contained in the NC Innovations Waiver can also be found in the *Records Management and Documentation Manual 45-2*

<http://www.ncdhhs.gov/mhddsas/statspublications/Manuals/rmdmanual-final.pdf>.

All Medicaid providers shall document services prior to seeking Medicaid payment. Providers shall perform follow-up documentation to reflect attempts to ascertain why a beneficiary is not participating in a service or support in accordance with the established schedule or plan.

7.2.1 Service Note

For Service Note requirements, refer to the *Records Management and Documentation Manual* (chapter 8 & 9). The following NC Innovation services require a full service note, which includes Items 1 through 13, under Contents of a Service Note, Chapter 8 of the *Records Management and Documentation Manual*;

- a. Crisis Services (including information as indicated in the beneficiary's intervention plan);
- b. Community Guide;
- c. Individual Directed Goods and Services (required for service component);
- d. Natural Supports Education; and
- e. Specialized Consultative Services.

7.2.2 Service Grid

For service grid requirements, refer to the *Records Management and Documentation Manual* (chapter 8 & 9). A service grid should include all elements 1 through 10, under Required Elements of a Service Grid, Chapter 8 of the Record Management and Documentation Manual. A service grid shall be

completed daily or per activity to reflect the service provided and may only be used for the following services:

- a. Community Networking;
- b. Day Supports (Services provided to children through Developmental Day Services- Typically Developing children, shall meet the requirements through the NC Division of Child Development's Child Care requirements, subchapter 3U- Child Day care Rules);
- c. In-Home Intensive Supports;
- d. In-Home Skill Building;
- e. Personal Care services;
- f. Residential Supports;
- g. Respite Care; and
- h. Supported Employment.

7.2.3 Signatures

All entries in the service record shall be signed with a full signature. A full signature is to include the credentials, degree or licensure for professional staff or the position of the individual who provided the service for paraprofessional staff. Refer to the *Records Management and Documentation Manual 45-2* (Chapter 9) for signature requirements.

7.2.4 Frequency of Service Documentation

All NC Innovations services require a daily or per activity service note or grid. The person who provided the service shall write and sign the service note or grid. The service note or grid to reflect services provided shall be documented on the day that the service was provided or no later than the next workday. If a service note or grid is not documented on the day the service was provided, it shall be considered a "late entry." Late entries are defined as those which are entered after the required time for documentation has expired. The entry shall be noted as a "late entry" and at a minimum the date the documentation was made and the date for which the documentation should have been documented.

For example, "Late Entry made on 2/15/12 for 2/14/12." The late entry must include a dated signature.

Service notes shall be made at the frequency necessary to indicate significant changes in the beneficiary's status, needs or changes in the ISP.

7.2.5 Corrections in the Service Record

Changes or modifications in the original documentation for the purpose of making a correction can be made at any time, when appropriate. Whenever corrections are necessary in the beneficiary's record, service providers shall refer to the procedures as noted in the *Records Management and Documentation Manual 45-2* (Chapter 9).

However, for quality assurance and reimbursement purposes, all necessary documentation or corrections to support billing shall be properly completed within seven (7) working days. Therefore, for billing purposes, corrections must be made within this prescribed timeframe.

7.2.6 Short-Range Goals, Task Analysis/Strategies

Service providers, Agencies With Choice, and Employers of Record are required to:

- a. develop and implement short-range goals;
- b. develop and implement task analysis/strategies;
- c. ensure short-range goals and task analysis or strategies are in place prior to plan implementation; and
- d. ensure short-range goals and task analysis or strategies are signed by the beneficiary or legal guardian.

7.2.7 Progress Summary

Service providers, Agencies With Choice, and Employers of Record are required to complete progress summaries for habilitative services to reflect the beneficiary's progress toward the short-range goal and long-range outcomes that have been implemented in the Individual Support Plan for any of the following Innovation services: Community Networking; Day Supports, In-Home Skill Building, In-Home Intensive Supports, Residential Supports and Supported Employment.

The Progress Summary should contain at a minimum:

- a. the beneficiary's name;
- b. date of the quarterly review and dates that the review covers;
- c. the goals reflected in the current Individual Support Plan;
- d. progress toward goals;
- e. recommendations for continuation, revision or termination of an outcome; and
- f. signature of the individual who completed the review.

The Progress Summary should be completed quarterly based on the beneficiary's ISP year and should be completed separately for each service. The quarterly progress note shall be documented within seven (7) working days of the close of the quarterly progress period. If a quarterly progress summary is not documented within seven (7) working days of the close of the service period, it shall be considered a "late entry." The documentation shall be noted as a "late entry" and shall include at a minimum the date the documentation was made and the date when the documentation should have been entered. For example, "Late Entry made on 2/14/08 for 2/7/08."

The qualified professional or other designated staff (who directly provided the service during the timeframe in which the service was provided) is responsible for gathering all relevant information from the other staff on the team and writing and signing a note that outlines the beneficiary's progress during that service period.

7.3 Service Specific Documentation

7.3.1 Assistive Technology Equipment and Supplies

The PIHP shall maintain the following:

- a. Assessment or recommendation by an appropriate professional that identifies the beneficiary's need(s) with regard to the equipment or supply being requested;
- b. Copy of the physician's signature certifying medical necessity is included with the request for equipment or supply. The recommendation must be less than one-calendar-year-old from the date the request is received by the PIHP. The assessment confirms medical need for the equipment and identifies the beneficiary's need(s) with regard to specific equipment being requested;
- c. The estimated life of the equipment as well as the length of time the beneficiary is expected to benefit from the equipment, shall be indicated in the request;
- d. An invoice from the supplier that shows the date the assistive technology equipment and supplies were provided to the beneficiary and the cost including related charges (for example, applicable delivery charges) shall be maintained by the PIHP;
- e. Long-range outcomes related to training needs associated with the beneficiary's/family's utilization and procurement of the requested equipment or adaptations are included in the Individual Support Plan as appropriate; and
- f. Documentation for Specific equipment and supplies as outline in the definition. See **Appendix C** for these requirements.

7.3.2 Community Guide

The provider agency shall maintain service notes signed by the individual providing the service that documents the date of the service, the amount of time involved in the service and a description of the activities related to the long-range outcomes and the short-range goals. The community guide shall complete a daily per event service note.

7.3.3 Community Networking

- a. The provider agency shall maintain a service note or grid signed by the individual providing the service that documents the date of the service, the amount of time involved in the service and a description of the activities related to the long-range outcomes and the short-range goals.
- b. For conferences, classes, and related materials purchased in conjunction with these, an invoice will be required.
- c. For Community Networking Transportation that is not part of the provision of a staffed service with an established per trip rate, the provider agency shall maintain a record with a signature of a representative providing the transportation.
- d. For Community Networking Transportation that is not part of the provision of a staffed service with a per mile charge, maintain a record that documents the date service was provided, the specific activity that the beneficiary is being transported to or from, and the mileage related to the transportation of

the beneficiary. The representative providing transportation shall sign the record.

7.3.4 Community Transition Services

The provider agency shall maintain the approved Community Transition Checklist and a copy of invoices from the suppliers that shows the date the community transition services were provided to the beneficiary and the cost of the services.

7.3.5 Crisis Services

The provider agency shall maintain a service note signed by the individual providing the service that documents the date of the service, the amount of time involved in the service and a description of the activities related to the long-range outcomes and the short-range goal regarding intervention plans.

7.3.6 Home Modifications

The PHIP shall maintain the following:

- a. Assessment or recommendation by an appropriate professional that identifies the beneficiary's need(s) with regard to the home modification being requested;
- b. Copy of the physician's signature certifying medical necessity is included with the request for home modifications;
- c. Long-range outcomes related to training needs associated with the beneficiary's or family's utilization and procurement of the requested adaptations are included in the Individual Support Plan as appropriate; and
- d. An invoice from the supplier that shows the date the materials or equipment was provided to the beneficiary, and cost including the related charges such as applicable delivery charges shall be maintained by the PIHP.

7.3.7 Individual Directed Goods and Services

- a. An invoice from the supplier that shows the date the good was provided to the beneficiary and the cost including related charges (for example, applicable delivery charges) shall be maintained by the Financial Support Agency or Agency With Choice.
- b. Services will require a service note signed by the individual providing the service that documents the date of the service, the amount of time involved in the service and a description of the activities related to the long-range outcomes and the short-range goals.

7.3.8 Natural Supports Education

- a. The provider agency shall maintain a service note signed by the individual providing the service that documents the date of the service, the amount of time involved in the service and a description of the activities related to the long-range outcomes and the short-range goal.
- b. For conferences, classes, and related materials purchased in conjunction with these, an invoice will be required.

7.3.9 Respite Service

The provider agency shall document respite services on a daily basis, and the documentation must contain the following components:

- a. Name of the beneficiary;
- b. record number;
- c. service provided;
- d. date of service;
- e. duration of service;
- f. task performed, including comments on any behaviors which are considered relevant to the beneficiary's continuity of care;
- g. that special instructions were followed; and
- h. signature (initials, if the full signature is included on the page when the use of a grid is used for documenting).

7.3.10 Specialized Consultation Services

The provider agency shall maintain the Intervention Plan (as applicable) and service note signed by the individual providing the service that documents:

- a. the date of the service;
- b. the amount of time involved in the service; and
- c. a description of the activities related to the long-range outcomes and the short-range goals.

7.3.11 Vehicle Adaptation

The PIHP shall maintain the following:

- a. Recommended equipment or modification shall be justified by an assessment from one or more of the following: physical therapist or occupational therapist specializing in vehicle modifications, or a rehabilitation engineer, or a vehicle adaptation specialist.
- b. Recommendation by a certified driving instructor for persons with disabilities, if the beneficiary is driving the vehicle to be modified.
- c. A physician's signature certifying medical necessity for the equipment or modification for the beneficiary.
- d. The recommendation must be less than one-calendar-year-old from the date the PIHP receives the request.
- e. The estimated life of the equipment as well as the length of time the beneficiary is expected to benefit from the equipment, shall be indicated in the request.
- f. An invoice from the supplier that shows the date the vehicle adaptation was provided for the beneficiary and the cost including related charges (for example, applicable delivery charges).
- g. Long-range outcomes related to training needs associated with the beneficiary's or family's utilization and procurement of the requested adaptations documented in the Individual Support Plan as appropriate.

7.4 General Records Administration and Availability of Records

NC Innovations service providers shall make service documentation available to the PIHP, DMH/DD/SAS, DMA, and CMS to review the documentation to support a claim for NC Innovations services rendered, when requested.

- a. Authorization letters for NC Innovations services;

- b. A copy of the Individual Support Plan, including current long-range outcomes;
- c. Service documentation required in **Subection 7.2** for service billed;
- d. Copies of any claims submitted to the PIHP for Medicaid billable services as well as related correspondence;
- e. Service providers who provide Before and After school services shall maintain a copy of the IEP and IFSP from the regular day program; and
- f. A signed copy of short-range goals and strategies to meet long-range outcomes in the Individual Support Plan.

7.5 How Long Records Must Be Kept

NC Innovations service providers have responsibility for fulfilling the record retention and disposition requirements for all the records generated within their agency. Record retention is addressed in the provider contract with the PIHP. The records pertaining to beneficiaries receiving NC Innovations services currently must be maintained by the NC Innovations Provider Agency for 11 years after the date of the last encounter for adults or for minors, 12 years from the 18th birthday. For more information regarding records retention, refer to the *Records Management and Documentation Manual* (Chapter 1).

7.6 Individual/Family Directed Services Documentation

Beneficiaries or their legal guardians who elect to direct their own services are required to have the individual workers document services following the above referenced criteria.

For beneficiaries electing the Employer of Record Model, the documentation will be stored in the beneficiary's or family's home. Should the individuals or their families decide to stop self-directing services under the Employer of Record Model, all documentation will be returned to the PIHP. For beneficiaries electing the Agency With Choice Model, the documentation will be stored as directed by the Agency With Choice.

The Quality Management Department at the PIHP will conduct annual reviews to include review of service documentation. For additional information regarding documentation for beneficiary or family directed services, refer to the PIHP Employer Handbook.

8.0 Policy Implementation/Revision Information

Original Effective Date: April 1, 2005

Revision Information:

Date	Section Revised	Change
08/01/2013	All sections and attachment(s)	New policy documenting current coverage, effective August 1, 2013, for Medicaid beneficiaries of NC Innovations Waiver Services. This policy is documenting the 1915 (c) waiver that began April 1, 2005. NC Innovations is authorized by a Medicaid Home and Community-Based Services (HCBS) Waiver granted by the Centers for Medicare and Medicaid Services (CMS) under Section 1915 (c) of the Social Security Act. The most current waiver renewal was approved to be effective, August 1, 2013 for five years. This policy will not apply to NCHC beneficiaries as it is a waiver, not a State Plan service.
08/28/2013	All sections and attachment(s)	Minor revisions to correct grammar and clarify coverage
03/01/2014	Section 2.3: Eligible Coverage Groups	Added the Health Coverage for Workers with Disabilities Basic Group as an eligible covered group
03/01/2014	Section 2.3: Eligible Coverage Groups	Removed typo from #11 under Aids for Daily Living
03/01/2014	Attachment C: Service Definitions	Added Food Thickeners for adults under the section Aids for Daily Living of the Assistive Technology Equipment and Supplies definition
03/01/2014	All sections and attachment(s)	Minor revisions to grammar, numbering, format, and template language
08/01/2014	All Sections and Attachments	Reviewed policy grammar, readability, typographical accuracy, and format. Policy amended as needed to correct, without affecting coverage.
08/01/2014	All Sections and Attachments	Updated policy template language.
10/01/2015	All Sections and Attachments	Updated policy template language and added ICD-10 codes to comply with federally mandated 10/1/2015 implementation where applicable.

Attachment A: Claims-Related Information

Provider(s) shall comply with the, *NCTracks Provider Claims and Billing Assistance Guide*, Medicaid bulletins, fee schedules, DMA's clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid and NCHC.

A. Claim Type

Professional (CMS-1500/837P transaction) billed through the PIHP.

B. International Classification of Diseases, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS)

Provider(s) shall report the ICD-10-CM and Procedural Coding System (PCS) to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10 edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for code description, as it is no longer documented in the policy.

A diagnosis of an Intellectual Disability or a related condition is must be present to bill for this service (42 CFR 435.1010). A related condition is defined as a severe, chronic disability that meets all of the following conditions:

1. It is attributable to—
 - a. Cerebral palsy or epilepsy; or
 - b. Any other condition, other than mental illness, found to be closely related to an intellectual disability because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of persons with intellectual disability, and requires treatment or services similar to those required for these persons.
2. It is manifested before the person reaches age 22.
3. It is likely to continue indefinitely.
4. It results in substantial functional limitations in three or more of the following areas of major life activity:
 - a. Self-care.
 - b. Understanding and use of language.
 - c. Learning.
 - d. Mobility.
 - e. Self-direction.
 - f. Capacity for independent living.

C. Code(s)

Provider(s) shall report the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for the code description, as it is no longer documented in the policy.

If no such specific CPT or HCPCS code exists, then the provider(s) shall report the procedure, product or service using the appropriate unlisted procedure or service code.

HCPCS Code(s)		
H2011 H2015 HQ	H2015 H2015 U1	H2016
HCPCS Code(s)		
T2014 T2020	H2015 U2	H2016 HI
HCPCS Code(s)		
H2025 HQ H2025 S5110 S5111 S5125 S5150 S5150 HQ S5150 US T1005 TE	T1005 TD S5165 T1015 T1999 T2013 T2013 HQ T2021 HQ T2021 T2025 T2025 HO	T2025 –U1 T2025 –U2 T2025 U3 T2027 T2029 T2034 T2038 T2039 T2041 T2041 U1

Unlisted Procedure or Service

CPT: The provider(s) shall refer to and comply with the Instructions for Use of the CPT Codebook, Unlisted Procedure or Service, and Special Report as documented in the current CPT in effect at the time of service.

HCPCS: The provider(s) shall refer to and comply with the Instructions For Use of HCPCS National Level II codes, Unlisted Procedure or Service and Special Report as documented in the current HCPCS edition in effect at the time of service

D. Modifiers

Provider(s) shall follow applicable modifier guidelines.

E. Billing Units

Provider(s) shall report the appropriate code(s) used which determines the billing unit(s). Billing units vary by service. Refer to **Attachment C, Service Definitions**, to determine the billing units for each service.

F. Place of Service

Services generally can be provided at a location that best meets the beneficiary’s needs. However some services must be provided at a specific location. Refer to the **Attachment C, Service Definitions**, for specific information about any limitations on when a service can be provided.

The following information applies to waiver beneficiaries living in facilities or those who are considering moving to facilities:

1. Individuals who are **new** beneficiaries to the waiver effective April 1, 2010, must live in private homes or facilities with six beds or less.

2. A new beneficiary is a person who was not enrolled in the NC Innovations waiver as of April 1, 2008. Beneficiaries transitioning with their respective PIHP from CAP-I/DD to NC Innovations are not considered new beneficiaries for the purposes of waiver eligibility.
3. Beneficiaries in the NC Innovations Waiver or individuals transitioning to NC Innovations may live in private homes or in the following types of facilities:
 - a. Supervised Living Type B for Children with DD; Type C for Adults with DD:
 - I. Supervised Living facilities may not exceed six beds except that any facility licensed on June 15, 2001, for more than six beds at that time are grandfathered in at no more than the facility's capacity. Facilities providing services to individuals who transitioned from the CAP IDD waiver were also grandfathered in at no more than the facilities capacity.
 - II. To participate in the waiver, these facilities must meet home and community characteristics
 - III. Any facility greater than six licensed beds will have no new admissions of waiver beneficiaries
 - IV. Newly developed facilities may participate only if they are licensed for 3 beds or less
 - b. Supervised Living Type F for Children or Adults with DD (Alternative Family Living)
 - I. Cannot exceed three beds
 - II. To participate in the waiver, these facilities must meet home and community characteristics
 - c. Family Care Homes
 - I. Cannot exceed six beds
 - II. To participate in the waiver, these facilities must meet home and community characteristics
 - III. Newly developed facilities may participate only if they are licensed for 3 beds or less

Home and Community Characteristics:

The following home and community living standards must be met by all facilities. They must be applied to all residents in the facility except where such activities or abilities are contraindicated specifically in a beneficiary's person-centered plan and applicable due process has been executed to restrict any of the standards or rights. Residents must be respectful to others in their community and the facility has the authority to restrict activities when those activities are disruptive or in violation of the rights of others living in the community.

Telephone Access

1. Must be available 24 hours a day, 7 days a week, 365 days a year
2. Operation Assistance must be available if necessary
3. Must be private
4. Residents are permitted to have and maintain personal phones in their rooms

Visitors

1. Shall be allowed at any time 24 hours a day, 7 days a week, 365 days a year
2. Does not require facility approval (although facility may require visitors to sign in or notify the facility administrator that they are in the facility)
3. Shall not have conduct requirements beyond respectful behavior toward other residents

Living Space

1. Must have no more than 2 residents to a room

2. If two individuals must share a room, they shall have a choice as to who their roommate is; under no circumstance will individuals be required to room together if either of them objects to sharing a room with the other
3. Must have the ability to work with the facility to achieve the closest optimal roommate situations
4. Residents shall have the ability to lock the rooms
5. Residents are allowed to decorate and keep personal items in the rooms
6. Residents are able to come and go at any hour
7. Residents shall have an individual personal lockable storage space available at any time
8. Residents are able to file anonymous complaints
9. Residents are permitted to have personal appliances and devices in their rooms

Service Customization

1. Residents shall be given maximum privacy in the delivery of their services
2. Residents shall be provided choice(s) in the structure of their service delivery (services and supports, and from where and whom)
3. Include the residents in care planning process as well as people chosen by the resident to attend care plan meetings
4. Provide the appropriate support(s) to ensure that the resident has an active role in directing the process
5. Person-centered planning process must be at convenient locations and times for the resident to attend
6. Ensure there are opportunities for the person-centered plan to be updated on a continuous basis

Kitchen

1. Must be accessible 24 hours a day /7 days a week/365 days a year
2. Must have accessible appliances
3. Residents shall have input on food options provided
4. Residents shall be allowed to choose who to eat meals with, including the ability to eat alone if desired

Group Activities

1. Residents shall be given the choice of participating in facility's recreational activities
2. Residents shall be allowed to choose who to participate in recreational activities with

Community Activities

1. Residents shall be given the ability to take part in community activities of their choosing
2. Residents shall be encouraged to remain active in their community
3. Residents shall not be restricted from participating in community activities of their choosing

Community Integration

1. Would anyone view this residence as part of the community?
2. How could the facility correct the above to become more integrated into the community?

Monitoring for Home and Community Character:

The State will require the managed care entities to conduct a review of each facility with four or more beds (# of beds specified in the 1915(c) Technical Review Guide) in which waiver beneficiaries live. The review will be annual for compliance with home and community requirements with active in-reach activities to provide consumer education and choice regarding other housing options. A State-approved standardized review tool will be used and reviews will be

conducted and reported to the State on a quarterly basis. Findings of non-compliance will result in immediate suspension of the facility's participation in the Innovations program. The facility will be given 30 days to come into compliance. At the end of the 30 days, an on-site visit will be made by the managed care entity and if the facility is fully compliant, the suspension will be lifted. If not, the facility will be terminated from the Innovations program and waiver beneficiaries residing in the facility will be required to move in order to continue participating in the waiver.

Services in the Home of a Direct Service Employee

If a beneficiary needs to receive Personal Care or Respite services in the home of a direct service employee, the Provider Agency, Employer of Record or Agency With Choice is required to complete the Health and Safety Checklist/Justification for Services form prior to the delivery of service in that home. The beneficiary or legally responsible person will be asked to sign this checklist. Beneficiaries should consider the provision of services in the direct service employee's home very carefully. While the checklist covers basic health and safety concerns, it does not provide for an independent review or cover the same areas that formal licensure of service locations covers.

Services Provided Outside North Carolina

In accordance with 42 CFR 431.62, waiver services to be delivered out of state are subject to the same requirements as services delivered out of state under the State Medicaid Plan. For beneficiaries living in counties bordering another state, the beneficiary may receive services from an enrolled NC Innovations Provider Agency located within 40 miles of the border of the county.

The following guidelines are to be used when beneficiaries are traveling out of state:

1. Services are for beneficiaries who have been receiving services from direct care staff while in state and who are unable travel without their assistance.
2. Beneficiaries who live in alternative family living homes or foster homes may receive services when traveling with their alternative family living or foster family out of state under these guidelines.
3. Beneficiaries who are residing in residential settings are allowed to go out of state on vacation with their residential provider and continue to receive services as long as the beneficiary's cost of care does not increase.
4. Written prior approval of the request for their staff to accompany beneficiaries out of state must be received from the supervisor of the staff person and the PIHP.
5. Waiver services may not be provided outside of the United States of America.
6. Provider agencies shall ensure that the staffing needs of all their beneficiaries can be met.
7. Supervision of the direct service employee and monitoring of care must continue.
8. The ISP must not be changed to increase services while out of state. Services can only be reimbursed to the extent they would be had they been provided in state, and only for the benefit of the beneficiary.
9. Respite services are not provided during out of state travel since the caregiver is present during the trip.
10. If licensed professionals are involved, Medicaid cannot waive any other state's licensure laws. A NC licensed professional may or may not be licensed to practice in another state.
11. Medicaid funds cannot be used to pay for room, board, or transportation costs of the beneficiary, family, or staff.
12. Provider agencies, Employers of Record and Agencies With Choice assume all liability for their staff when out of state.

G. Co-payments

For Medicaid refer to Medicaid State Plan, Attachment 4.18-A, page 1, located at <http://www.ncdhhs.gov/dma/plan/sp.pdf>.

For NCHC refer to G.S. 108A-70.21(d), located at http://www.ncleg.net/EnactedLegislation/Statutes/HTML/BySection/Chapter_108A/GS_108A-70.21.html.

Co-payments for waiver services are not applicable to beneficiaries of NC Innovations waiver services.

H. Reimbursement

Providers are reimbursed by the PIHP.

Attachment B: Terms of Service

A. Absences, Movement from the PIHP Area and Terminations

If the beneficiary is hospitalized, placed in an ICF-IID facility, admitted to a state psychiatric facility, becomes an inmate in a public correctional institution or will be absent for 30 days or more, DSS will direct the care coordinator about continuing Medicaid eligibility.

B. Hospitalizations

When a beneficiary is admitted to a hospital, the care coordinator suspends the delivery of NC Innovations funding with the exception of Treatment Planning Case Management (Care Coordination) that may be provided for the purposes of discharge planning up to 60 calendar days prior to discharge, as long as activities do not occur that duplicate the services provided by hospital staff. No NC Innovations Services may be billed to Medicaid for a beneficiary who is hospitalized. The Care Coordinator notifies the service providers of the suspension and the projected resumption date. The length of time the beneficiary is hospitalized determines what else must be done as detailed below.

1. 30 calendar days or less: normal tasks of coordinating the temporary changes in services with providers, monitoring the beneficiary's situation, and working with hospital discharge planners and others to assure services and supports upon discharge. The care coordinator notifies the DSS staff of the admission. Medicaid services, supplies, and equipment cannot be provided or billed to Medicaid during hospitalizations.
2. Over 30 calendar days: DSS staff is notified. Medicaid staff determines when the NC Innovations indicator on the Eligibility Information System (EIS) is to be removed. This removes the beneficiary from NC Innovations funding. Once the DSS staff determines the effective date of the termination, the care coordinator follows the termination procedures. If the person later wishes to be re-enrolled to NC Innovations, the PIHP and care coordinator considers the person a new beneficiary. A beneficiary re-enrolled to NC Innovations within the same Waiver year re-enters the slot that he or she left.

C. Admission to ICF-IID or Other Institution

When a NC Innovations funded beneficiary is admitted to an ICF-IID facility, nursing facility, or psychiatric institutional setting other than a hospital, the beneficiary shall be terminated from NC Innovations on the date of institutionalization. If the beneficiary wishes to resume NC Innovations participation upon discharge, the PIHP considers the person a new beneficiary.

D. Temporary Absence from Area

When a beneficiary temporarily leaves the area, the care coordinator suspends the delivery of NC Innovations services. The care coordinator tracks the length of the absence as extended absences can affect Medicaid eligibility. If the absence is 30 calendar days or more, the care coordinator notifies the DSS staff. The DSS staff determines when the NC Innovations indicator on the Eligibility Information System (EIS) is to be removed. Once the Medicaid staff determines the effective date of the termination, the care coordinator follows the termination procedures.

E. Service Breaks

The beneficiary may miss a service for a variety of reasons. Holidays, family vacations, weather conditions, illnesses, and scheduling conflicts can cause brief interruptions in services. Breaks in service are to be documented by the provider and monitored by the care coordinator. When such an interruption occurs, the service may be rescheduled, depending on the nature of the service missed. Providers should keep in mind the limits on sets of services when determining if services may be rescheduled, especially if multiple providers serve the beneficiary. The provider contacts the care coordinator if there are questions regarding the rescheduling of the service. This exception to providing services as approved on the plan may not be used if the beneficiary missed services while he or she was ineligible for Medicaid or NC Innovations. Services missed during periods of ineligibility may not be rescheduled. Service breaks do not require Level I Back-Up Staffing Incident Reports.

F. Terminations

Termination may be due to a variety of reasons, including ineligibility for Medicaid, moving outside the catchment area, institutionalization, or failure to qualify for program participation. Depending on the reason for termination, it may be initiated by the county DSS, the PIHP, or the beneficiary or legal guardian.

Terminations must be completed with full regard for the beneficiary's rights, including those related to a fair hearing. All terminations **must** be coordinated with DSS. Written notifications of terminations must be sent to the beneficiary or legal guardian, the PIHP and DSS.

G. DSS Terminates Medicaid Eligibility

If DSS proposes to terminate the beneficiary's Medicaid eligibility, it will send a notice to the beneficiary or legal guardian. Medicaid rules determine the timing of the notice. In many instances, it is sent at least 10 days prior to the proposed date of action. The notice states the proposed termination date, the reason for termination, and appeal rights. Medicaid terminations usually are effective the last day of the month. In some instances, the beneficiary's eligibility for Medicaid will continue through the appeal process. The beneficiary may continue NC Innovations services as long as the beneficiary remains eligible for Medicaid and NC Innovations.

H. ISP is Disapproved

If the PIHP does not approve a beneficiary's Individual Support Plan, due process is followed per the Medicaid Billing Guide.

I. Beneficiary Institutionalized or Beneficiary's Level of Care Changes

If the beneficiary is admitted to an ICF-IID or nursing facility or if the beneficiary's Level of Care is changed to Intermediate, Skilled, or Hospital Level of Care on a Level of Care Form (or on an FL-2), the care coordinator terminates the beneficiary on the date of admission or date of change of Level of Care. Also, if the beneficiary is admitted to a hospital for a stay longer than 30 calendar days, the care coordinator consults with DSS about possible termination.

The PIHP sends written notification of the termination to DSS, informs the beneficiary or legal guardian in writing of the termination, and sends written notification to Provider Agencies, Employers of Record, Financial Support Agencies or Agencies With Choice to stop services.

J. Beneficiary Moves Out of Area

If the termination of NC Innovations is due to the beneficiary moving out of the state, the termination is usually the last day of the month. The PIHP notifies DSS of the termination. Notification of termination must be written.

K. Beneficiary Dies

If the beneficiary dies, the care coordinator notifies the PIHP, and the PIHP notifies DSS and Provider Agencies of the death. Medicaid shall not pay for any services after the date of the beneficiary's death. Notification of termination must be written. DMH/DD/SAS Rules regarding death reporting are followed.

L. Other North Carolina Innovations Terminations

If the termination of NC Innovations is for reasons other than those covered above, the care coordinator coordinates the proposed termination date with DSS. The PIHP must give the person at least 10 days written advance notice of the proposed termination. The reason for termination and the beneficiary's appeal rights must be included. The date of termination is the last day of the month of NC Innovations eligibility. When the termination is final, the care coordinator notifies the PIHP of the termination in writing. The PIHP notifies provider agencies of the termination.

Attachment C: Service Definitions

NC Innovations service definitions and the specific provider requirements for each definition are included in the following pages

Assistive Technology Equipment and Supplies: T2029

Assistive Technology Equipment and Supplies are necessary for the proper functioning of items and systems, whether acquired commercially, modified, or customized, that are used to increase, maintain, or improve functional capabilities of beneficiaries. This service covers purchases, leasing, shipping costs, and as necessary, repair of equipment required to enable beneficiaries to increase, maintain or improve their functional capacity to perform daily life tasks that would not be possible otherwise. All items must meet applicable standards of manufacture, design, and installation. The Individual Support Plan clearly indicates a plan for training the beneficiary, the natural support system and paid caregivers on the use of the requested equipment and supplies. A written recommendation by an appropriate professional is obtained to ensure that the equipment will meet the needs of the beneficiary. A physician's signature certifying medical necessity shall be included with the written request for Assistive Technology Equipment and Supplies.

Assistive Technology: Equipment and Supplies covers the following:

I. Aids For Daily Living

1. Adaptive equipment to enable a beneficiary to feed him/herself (e.g. utensils, gripping aid for utensils, adjustable universal utensil cuff, utensil holder, scooper, trays, cups, bowls, plates, plate guards, non-skid pads for plates/bowls, wheelchair cup holders, and glasses that are specifically designed to allow a beneficiary to feed him/herself)
2. Adaptive hygiene and dressing aids
3. Adaptive switches and attachments
4. Adaptive toileting and bath chairs
5. Adaptive toothbrushes
6. Assistive devices for beneficiaries with hearing and vision loss (e.g. assistive listening devices; TDD, large visual display devices, Braille screen communicators, FM Systems, volume control large print telephones, and teletouch systems)
7. Non-disposable clothing protectors
8. Non-disposable incontinence items with disposable liners for use by beneficiaries ages three and above
9. Nutritional supplements for adults recommended by a physician that are taken by mouth rather than by tube and which are not covered by Medicaid State Plan as a Home Infusion Therapy benefit. These are included in the Individual Support Plan and Individual Budget and are billed to the PIHP.
10. Food thickeners for adults with Dysphagia
11. Adaptive clothing to meet disability specific needs of the participant
12. Toilet trainer with anterior and lateral supports

II. Gross Motor Development

1. Adaptive Tricycles for gross motor development

III. Environmental Control

1. Specialized Global Positioning (GPS) Devices, when recommended by a licensed psychologist or licensed psychological associate and accompanied by a behavior support plan that describes how paid or natural supports will supervise the beneficiary who is using the recommended device.
2. Computer equipment, adaptive peripherals and adaptive workstation to accommodate access from bed or power mobility device when it allows the beneficiary control of his or her environment, reduces paid supports, assists in gaining independence, or when it can be demonstrated that it is necessary to protect the health and safety of the beneficiary.
3. Software is approved only when required to operate accessories included for environmental control or to support the beneficiary in planning and budgeting.

Computers will not be authorized to improve socialization or educational skills, to provide recreation or diversion activities, or to be used by any other person other than the beneficiary.

IV. Positioning Systems

1. Standers with trays and attachments (for adults only – children may receive this under the state plan)
2. Prone boards with attachments (for adults only – children may receive this under the state plan)
3. Positioning chairs and sitters for beneficiaries who do not use a wheelchair for mobility
4. Therapeutic balls
5. Therapy mats when used with adaptive positioning devices
6. Car seats that are necessary for positioning children and adults who require specialized seating while being transported due to chronic health issues. Car seats for behavioral restraint will not be approved

V. Alert Systems

Alert systems are limited to beneficiaries who live alone or who are alone for significant parts of the day, have no regular caregiver for extended periods of time and who would otherwise require extensive routine supervision. This service may also be used by beneficiaries who live in private homes if the use of the equipment results in a fading or reduction of paid services or prevents the need for additional paid services. Equipment purchase and monthly monitoring charges are covered for the following:

1. Personal Emergency Response Systems (PERS)
2. Alarm systems/alert systems, including auditory, vibratory, heat sensing and visual to ensure the health and safety of the beneficiary, as well as signaling devices for beneficiaries with hearing and visual loss
3. Telephone Line Restoration Systems when beneficiary fails to hang the phone up during suspected health and safety issues
4. Inactivity Motion Detectors
5. Lockboxes to enable emergency responders to enter the beneficiary's home without damage to windows or doors
6. Medical alarms that offer live two-way voice communication without handheld devices (such as telephones), including remotely located speakers and microphones.
7. Medical alarms that connect beneficiaries directly to family members or friends who are willing and able to respond to emergency requests from the beneficiary. The beneficiary's Individual Support Plan identifies the natural support systems who have agreed to respond to emergency requests from the beneficiary.
8. Medication Reminder Systems and/or Monitored Automatic Pill Dispensers
9. Pre-paid, pre-programmed cellular phones that allow a beneficiary who is participating in

employment or community activities without paid or natural supports and who may need assistance due to an accident, injury, or inability to find the way home. The beneficiary's Individual Support Plan outlines a protocol that is followed if the beneficiary has an urgent need to request help while in the community. Cellular phones are not for convenience or general purpose use and costs associated with non-emergency use are excluded.

10. Supervised Photoelectric Smoke Detectors

VI Repair of Equipment

1. Repair of Equipment is covered for items purchased through the waiver or purchased prior to waiver participation, as long as the item is identified within this service definition and the cost of the repair does not exceed the cost of purchasing a replacement piece of equipment. The waiver beneficiary must own any equipment that is repaired.
2. Waiver funding will not be used to replace equipment that has not been reasonably cared for and maintained.

Exclusions	<ol style="list-style-type: none"> 1. Items that are not of direct or remedial benefit to the beneficiary are excluded from this service. 2. Computer desks and other furniture items are not covered. 3. Service and maintenance contracts and extended warranties; and equipment or supplies purchased for exclusive use at the school/home school are not covered.
Limits on amount, frequency, or duration	The service is limited to expenditures of \$15,000 over the duration of the waiver. This limit does not include nutritional supplements and monthly alert monitoring system charges.
Service Delivery Method	<input checked="" type="checkbox"/> Provider Directed <input type="checkbox"/> Individual/Family Directed

Provider Type	License	Certification	Other Standard
Specialized Vendors	Applicable state/local business license		Meets applicable state and local requirements and regulations for type of device that the business is providing
Alert Response Centers	Applicable state/local business license		Response Centers must be staffed by trained individuals, 24 hours/day, 365 days/year Meets applicable state and local requirements and regulations for type of device that the vendor is providing
Durable Medical Equipment Providers	Applicable state/local business license	DMA enrolled vendor	Meets applicable state and local requirements and regulations for type of device that the business is providing
Home Care Agencies	Licensed by the NC DHHS, Division of Health Services Regulation, in accordance with NCGS 131E, Article 6, Part C	DMA enrolled vendor	Meets applicable state and local requirements and regulations for type of device that the business is providing
Commercial/Retail Businesses	Applicable state/local business license		Meets applicable state and local requirements and regulations for type of device that the business is providing

Community Guide: Periodic-T2041 U1; Monthly-T2041

Community Guide Services provide support to beneficiaries and planning teams that assist beneficiaries in developing social networks and connections within local communities. The purpose of this service is to promote self-determination, increase independence and enhance the beneficiary's ability to interact with and contribute to his or her local community. Community Guide Services emphasize, promote and coordinate the use of natural and generic supports (unpaid) to address the beneficiary's needs in addition to paid services.

These services also support beneficiaries, representatives, and Managing Employers who direct their own waiver services by providing direct assistance in their beneficiary direction responsibilities. Community Guide is mandatory for all Employers of Record until competence in directing service is demonstrated. Community Guide Services are intermittent and fade as community connections develop and skills increase in beneficiary direction. Community Guides assist and support (rather than direct and manage) the beneficiary throughout the service delivery process. Community Guide Services are intended to enhance, not replace, existing natural and community resources.

Specific functions are:

1. Assistance in forming and sustaining a full range of relationships with natural and community supports that allows the beneficiary meaningful community integration and inclusion
2. Support to develop social networks with community organizations to increase the beneficiary's opportunity to expand valued social relationships and build connections within the beneficiary's local community
3. Assistance in locating and accessing non-Medicaid community supports and resources that are related to achieving ISP outcomes: this includes social and educational resources, as well as natural supports
4. Instruction and counseling which guides the beneficiary in problem solving and decision making
5. Advocacy and collaborating with other individuals and organizations on behalf of the beneficiary
6. Supporting the person in preparing, participating in and implementing plans of any type (IEP, ISP, or service plan)
7. Providing training on the Individual and Family Directed Supports Option, if the beneficiary is considering directing services and supports (Agency With Choice and Employer of Record Models)
8. Guidance with management of the Individual & Family directed budget (Agency With Choice and Employer of Record Model)
9. Coordinating services with the Financial Support Services provider, if the individual is self-directing services under the Employer of Record Model, including guidance on use of the Individual and Family Directed (Beneficiary-Directed Budget) (Employer of Record Model)
10. Providing information on recruiting, hiring, managing, training, evaluating, and changing support staff, if the beneficiary is self-directing services (Agency With Choice and Employer of Record Models)
11. Assisting with the development of schedules and outlining staff duties, if the beneficiary is self-directing services or considering directing services and supports (Agency With Choice and Employer of Record Models)
12. Assisting with understanding staff financial forms, qualifications and record keeping requirements, if the beneficiary is self-directing services (Agency With Choice and Employer of Record Models)
13. Providing on-going information/coaching/technical assistance to assure that beneficiaries and their families/ representatives understand the responsibilities involved with beneficiary direction,

<p>including reporting on expenditures and other relevant information and training (Agency With Choice and Employer of Record Models)</p> <p>14. Coordinating services with the Agency with Choice if the beneficiary is directing services under the Agency with Choice Model</p> <p>15. Assistance in locating options for renting or purchasing a personal residence, assisting with purchasing furnishings for the personal residence</p>			
Exclusions		<ol style="list-style-type: none"> 1. This service does not duplicate care coordination. Care coordination under managed care includes assisting the beneficiary in the development of the ISP, completing or gathering evaluations inclusive of the re-evaluation of the level of care, monitoring the implementation of the ISP, choosing service providers, coordination of benefits and monitoring the health and safety of the beneficiary consistent with 42 CFR 438.208(c). 2. The provider of Community Guide Services that does not provide Agency With Choice Services may only additionally provide Community Transition. 3. The Community Guide Services Provider may provide Agency With Choice Services to the same individual. If the Community Guide Services Provider is providing Agency With Choice Services to a beneficiary, the Provider may additionally provide Community Transition, Financial Support Services, Individual Goods and Services, and Primary Crisis Response Services to the individual as well as the NC Innovations Services that an Agency With Choice may typically provide. 4. Community Guide Services are only to be used to provide support for Beneficiary Direction activities as approved in this waiver, Individual and Family Directed Supports: Employer of Record and Agency With Choice Models. 	
Limits on amount, frequency, or duration			
Service Delivery Method		<ul style="list-style-type: none"> ■ Provider Directed ■ Individual/Family Directed 	
Provider Type	License	Certification	Other Standard
Employee in a beneficiary-directed arrangement			<p>NC G.S. 122C as applicable</p> <p>Approved by Employer of Record or recommended by Managing Employer and approved by Agency with Choice</p> <p>At least 18 years old</p> <p>If providing transportation, have a valid North Carolina driver's license or other valid driver's license, a safe driving record and an acceptable level of automobile liability insurance</p> <p>Criminal background checks present no health and safety risk to beneficiary</p>

			<p>Not listed in the North Carolina Health Care Abuse Registry</p> <p>Qualified in CPR and First Aid</p> <p>Qualified in the customized needs of beneficiary as described in the ISP</p> <p>High school diploma or equivalency (GED)</p> <p>Supervised by the Employer of Record or Managing Employer</p> <p>For service directed by the Agency with Choice, paraprofessionals providing this service must be supervised by a qualified professional. Supervision must be provided according to supervision requirements specified in 10A NCAC 27G.0204 (b) (c) (f) and according to licensure or certification requirements of the appropriate discipline.</p> <p>Upon enrollment with the PIHP, the Agency With Choice must have achieved national accreditation with at least one of the designated accrediting agencies.</p> <p>The Agency With Choice must be established as a legally constituted entity capable of meeting all the requirements of the PIHP.</p> <p>Meets Community Guide Competencies as specified by DMA.</p>
<p>Provider Agencies</p>		<p>NC G.S. 122C, as applicable</p>	<p>Approved as a provider in the PIHP provider network:</p> <p>Agency staff that work with beneficiaries: Are at least 18 years old</p> <p>If providing transportation, have a valid North Carolina or other valid driver's license, a safe driving record and an acceptable level of automobile liability insurance</p> <p>Criminal background checks present no health and safety risk to beneficiary</p> <p>Not listed in the North Carolina Health Care Abuse Registry</p> <p>Qualified in CPR and First Aid</p>

			<p>Qualified in the customized needs of the beneficiary as described in the ISP</p> <p>High school diploma or high school equivalency (GED)</p> <p>Paraprofessionals providing this service must be supervised by a qualified professional. Supervision must be provided according to supervision requirements specified in 10A NCAC 27G.0204 (b) (c) (f) and according to licensure or certification requirements of the appropriate discipline.</p> <p>Upon enrollment with the PIHP, the organization must have achieved national accreditation with at least one of the designated accrediting agencies.</p> <p>The organization must be established as a legally constituted entity capable of meeting all of the requirements of the PIHP.</p> <p>Meets Community Guide competencies as specified by DMA.</p>
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Community Networking: Service-Individual H2015; Group H2015 HQ; Class and Conference- H2015U1; Transportation- H2015U2

Community Networking services provide individualized day activities that support the beneficiary’s definition of a meaningful day in an integrated community setting, with persons who are not disabled. This service is provided separate and apart from the beneficiary’s private residence, other residential living arrangement, and/or the home of a service provider. These services do not take place in licensed facilities and are intended to offer the beneficiary the opportunity to develop meaningful community relationships with non-disabled individuals. Services are designed to promote maximum participation in community life while developing natural supports within integrated settings. Community Networking services enable the beneficiary to increase or maintain their capacity for independence and develop social roles valued by non-disabled members of the community. As beneficiaries gain skills and increase community connections, service hours should fade; however a formal fading plan is not required.

Community Networking services consist of:

1. Participation in adult education;
2. Development of community based time management skills;
3. Community based classes for the development of hobbies or leisure/cultural interests;
4. Volunteer work;
5. Participation in formal/informal associations and/or community groups;
6. Training and education in self-determination and self-advocacy;
7. Using public transportation;
8. Inclusion in a broad range of community settings that allow the beneficiary to make community connections;
9. For children, this service includes staffing supports to assist children to participate in day care/after school summer programs that serve typically developing children and are not funded by Day Supports.
10. Transportation when the activity does not include staffing support and the destination of the transportation is an integrated community setting or a self-advocacy activity. Payments for transportation are an established per trip charge or mileage.

This service includes a combination of training, personal assistance and supports as needed by the beneficiary during activities. Transportation to/from the beneficiary’s residence and the training site(s) is included.

Payment for attendance at classes and conferences is also included.

Exclusions	<p>This does not include the cost of hotels, meals, materials or transportation while attending conferences.</p> <p>This service does not include activities that would normally be a component of a beneficiary’s home/residential life or services.</p> <p>This service does not pay day care fees or fees for other childcare related activities.</p> <p>The waiver beneficiary may not volunteer for the Community Networking service provider.</p>
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	<p>The service may not duplicate services provided under Community Guide, Day Supports, In-Home Intensive Supports, In- Home Skill Building, Personal Care, Residential Supports, and/or Supported Employment services.</p> <p>This service may not be furnished/claimed at the same time of day as Day Supports, In-Home Intensive Supports, In- Home Skill Building, Personal Care, Residential Supports, Respite, Supported Employment or one of the state plan Medicaid services that works directly with the beneficiary.</p> <p>For beneficiaries who are eligible for educational services under the Individuals With Disability Educational Act, Community Networking does not included transportation to/from school settings. This includes transportation to/from beneficiary’s home or any community location where the beneficiary may be receiving services before/after school.</p> <p>This service does not pay for overnight programs of any kind.</p> <p>Memberships of any type are not covered under this definition.</p> <p>Classes that offer one-to-one instruction and are in a nonintegrated community setting are not covered.</p>		
Limits on amount, frequency, or duration	<p>Payment for attendance at classes and conferences will not exceed \$1000/ per beneficiary plan year. The amount of community networking services is subject to the “Limits on Sets of Services.” The amount of community networking services is subject to the amount of the beneficiary’s Support Need Matrix Category Budget if currently phased into the Support Needs Matrix.</p>		
Service Delivery Method	<p>■ Provider Directed ■ Individual/Family Directed</p>		
Provider Type	Licens e	Certification	Other Standard
Employee in a beneficiary-directed arrangement			<p>NC G.S.122C as applicable</p> <p>Approved by employer of record or recommended by Managing Employer and approved by Agency with Choice</p> <p>Are at least 18 years old</p> <p>If providing transportation, have a valid North Carolina or other valid driver’s license, a safe driving record and an acceptable level of automobile liability insurance</p> <p>Criminal background check presents no health and safety risk to beneficiary</p> <p>Not listed in the North Carolina Health Care Abuse Registry</p> <p>Qualified in CPR and First Aid</p>

		<p>Staff that work with beneficiaries must be qualified in the customized needs of the beneficiary as described in the ISP</p> <p>High school diploma or equivalency (GED)</p> <p>Supervised by the Employer of Record and the Managing Employer</p> <p>For service directed by the Agency with Choice, paraprofessionals providing this service must be supervised by a qualified professional. Supervision must be provided according to supervision requirements specified in 10A NCAC 27G.0204 (b) (c) (f) and according to licensure or certification requirements of the appropriate discipline.</p> <p>State Nursing Board Regulations must be followed for tasks that present health and safety risks to the beneficiary as directed by the PIHP Medical Director or Assistant Medical Director</p> <p>Agencies with Choice follow the NC State Nursing Board regulations</p> <p>Upon enrollment with the PIHP, the Agency with Choice must have achieved national accreditation with at least one of the designated accrediting agencies.</p> <p>The Agency with Choice must be established as a legally constituted entity capable of meeting all of the requirements of the PIHP.</p>
<p>Provider Agencies</p>		<p>Approved as a provider in the PIHP provider network:</p> <p>Agency staff that work with beneficiaries: Are at least 18 years old</p> <p>If providing transportation, have a valid North Carolina or other valid driver’s license, a safe driving record and an acceptable level of automobile liability insurance</p> <p>Criminal background checks present no health and safety risk to beneficiary</p> <p>Not listed in the North Carolina Health Care Abuse Registry</p> <p>Qualified in CPR and First Aid</p>

			<p>Staff that work with beneficiaries must be qualified in the customized needs of the beneficiary as described in the ISP</p> <p>High school diploma or high school equivalency (GED)</p> <p>Paraprofessionals providing this service must be supervised by a qualified professional. Supervision must be provided according to supervision requirements specified in 10A NCAC 27G.0204(b) (c) (f) and according to licensure or certification requirements of the appropriate discipline.</p> <p>Upon enrollment with the PIHP, the organization must have achieved national accreditation with at least one of the designated accrediting agencies.</p> <p>The organization must be established as a legally constituted entity capable of meeting all of the requirements of the PIHP.</p>
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Community Transition: T2038

Community Transition is one-time, set-up expenses for adult beneficiaries to facilitate their transition from a Developmental Center (institution), community ICF-IID Group Home, nursing facility or another licensed living arrangement (group home, foster home, or alternative family living arrangement) to a living arrangement where the beneficiary is directly responsible for his or her own living expenses. This service may be provided only in a private home or apartment with a lease in the beneficiary's/legal guardian's/representative's name or a home owned by the beneficiary.

Covered transition services are:

1. Security deposits that are required to obtain a lease on an apartment or home;
2. Essential furnishings, including furniture, window coverings, food preparation items, bed/bath linens;
3. Moving expenses required to occupy and use a community domicile;
4. Set-up fees or deposits for utility or service access, including telephone, electricity, heating and water; and/or
5. Service necessary for the beneficiary's health and safety such as pest eradication and one-time cleaning prior to occupancy.

Community Transition expenses are furnished only to the extent that the beneficiary is unable to meet such expense or when the support cannot be obtained from other sources. These supports may be provided only once to a waiver beneficiary. These services are available only during the three-month period that commences one month in advance of the beneficiary's move to an integrated living arrangement.

The Community Transition Checklist is completed to document the items requested under this definition. The Checklist is submitted to the PIHP by the agency that is providing the services.

Exclusions	Community Transition does not include monthly rental or mortgage expense; regular utility charges; and/or household appliances or diversional/recreational items such as televisions, VCR players and components and DVD players and components. Service and maintenance contracts and extended warranties are not covered. Community Transition services can be accessed only one time from either the 1915b or 1915c waiver.
Limits on amount, frequency, or duration	The cost of Community Transition has a life time limit of \$5000.00 per beneficiary. Community Transition includes the actual cost of services and does not include provider overhead charges.
Service Delivery Method	<input checked="" type="checkbox"/> Provider Directed <input type="checkbox"/> Individual/Family Directed

Provider Type	License	Certification	Other Standard
Specialized Vendor Suppliers			Meets applicable state and local regulations for type of service that the provider/supplier is providing as approved by PIHP
Agencies that provide Community Guide Services			NC G.S. 122C, as applicable Credentialed as a provider in the PIHP provider network Meets applicable regulations for type of service that the provider/supplier is providing as approved by PIHP
Commercial/Retail Businesses	Applicable state/local business license		Meets applicable regulations for type of service that the provider/supplier is providing as approved by PIHP

Crisis Services: Primary Response-H2011; Behavioral Consultation-T2025-U3 ; Out of Home-T2034

Crisis Services is a tiered approach to support waiver beneficiaries when crisis situations occur that present a threat to the beneficiary's health and safety or the health and safety of others. These behaviors may result in the beneficiary losing his or her home, job, or access to activities and community involvement. Crisis Services is an immediate intervention available 24 hours per day, 7 days per week to support the person who is primarily responsible for the care of the beneficiary. Crisis Services is provided as an alternative to institutional placement or psychiatric hospitalization. Service authorization can be accessed by telephone or planned through the ISP to meet the needs of the beneficiary. Following service authorization, any needed modifications to the Individual Support Plan and Individual Budget will occur within five working days of the date of verbal service authorization.

Primary Crisis Response

Trained staff is available to provide "first response" crisis services to waiver beneficiaries they support, in the event of a crisis. These activities include:

1. Assess the nature of the crisis to determine whether the situation can be stabilized in the current location, or if a higher-level intervention is needed;
2. Determine and contact agencies needed to secure higher level intervention or out of home services;
3. Provide direction to staff present at the crisis or provide direct intervention to de-escalate behavior or protect others living with the beneficiary during behavioral episodes;
4. Contact the care coordinator following the intervention to arrange Crisis Behavioral Consultation for the beneficiary; and/or
5. Provide direction to service providers who may be supporting the beneficiary in day programming and community settings, including direct intervention to de-escalate behavior or protect others during behavioral episodes (enhanced staffing to provide one additional staff person in settings where the beneficiary may be receiving other services).

Crisis Behavioral Consultation

Crisis Behavioral Consultation is available to beneficiaries that have intensive, significant, challenging behaviors that have resulted in a crisis situation requiring the development of a Crisis Support plan.

These activities include:

1. Development or refinement of interventions to address behaviors or issues that precipitated the behavioral crisis and/or
2. Training and technical assistance to the Primary Responder and others who support the beneficiary on crisis interventions and strategies to mitigate issues that resulted in the crisis.

Out of Home Crisis

Out of Home Crisis is a short-term service for a beneficiary experiencing a crisis and requiring a period of structured support and or/programming. The service takes place in a licensed facility. Out-of-home crisis may be used when a beneficiary cannot be safely supported in the home, due to his or her behavior and implementation of formal behavior interventions have failed to stabilize the behaviors and/or all other approaches to insure health and safety have failed. In addition, the service may be used as a planned respite stay for waiver beneficiaries who are unable to access regular respite due to the nature of their behaviors.

Crisis Services will be authorized in 14 calendar day increments. In situations requiring Crisis Services in excess of 14 calendar days, the PIHP must approve such authorization based on review of a transition plan that details the transition of the beneficiary from crisis supports to other appropriate services.

Exclusions	This service may not duplicate services provided under Specialized Consultation Services.		
Limits on amount, frequency, or duration	Crisis Services is considered an “Add On” to the Individual Budget and should be used as clinically appropriate for the beneficiary.		
Service Delivery Method	<input checked="" type="checkbox"/> Provider Directed <input type="checkbox"/> Individual/Family Directed		
Provider Type	License	Certification	Other Standard
Provider Agencies (Primary Crisis Response Services)			<p>Approved as a provider in the PIHP provider network</p> <p>Agency staff that work with beneficiaries: Are at least 18 years of age</p> <p>If providing transportation, have a valid North Carolina driver’s license or other valid driver’s license, a safe driving record and an acceptable level of automobile liability insurance</p> <p>Criminal background check presents no health and safety risk to beneficiary</p> <p>Not listed in the North Carolina Health Care Abuse Registry</p> <p>Qualified in CPR, NCI, and First Aid</p> <p>Qualified in the customized needs of the beneficiary as described in the ISP</p> <p>Provided by a qualified professional in the field of developmental disabilities</p> <p>Meets Crisis Services Competencies specified by DMA.</p> <p>Upon enrollment with the PIHP, the organization must have achieved national accreditation with at least one of the designated accreditation agencies.</p> <p>Organization must be established as a legally constituted entity, capable of meeting all the requirements of the PIHP.</p>
Independent Practitioners or Provider Agencies	Licensure specific to discipline as		Approved by the PIHP as an Independent Practitioner or as a provider in the PIHP provider network

<p>(Crisis Behavioral Consultation)</p>			<p>Staff that work with beneficiaries: Are at least 18 years old</p> <p>Criminal background check presents no health and safety risk to beneficiary</p> <p>Not listed in the North Carolina Health Care Abuse Registry</p> <p>Staff holds NC license for psychologist or psychological associate</p> <p>Meets Crisis Services Competencies specified by DMA.</p> <p>Qualified in customized needs of the beneficiary as described in the ISP</p> <p>Upon enrollment with the PIHP, the organization must have achieved national accreditation with at least one of the designated accreditation agencies.</p> <p>If a provider agency the organization must be established as a legally constituted entity, capable of meeting all the requirements of the PIHP</p>
<p>Provider Agencies who operate licensed facilities</p>	<p>NC G.S, 122C 10 NCAC 27G.5100 or waiver licensure granted by licensing agency</p>		<p>Approved as a provider in the PIHP provider network</p> <p>Agency staff that work with beneficiaries: Are at least 18 years old</p> <p>If providing transportation, have a valid North Carolina or other valid driver's license, a safe driving record and an acceptable level of automobile liability insurance</p> <p>Criminal background check presents no health and safety risk to beneficiary</p> <p>Not listed in the North Carolina Health Care Abuse Registry</p> <p>Qualified in CPR and First Aid</p> <p>Qualified in the customized needs of the beneficiary as described in the ISP</p> <p>Meets Crisis Services Competencies specified by DMA.</p> <p>High school diploma or high school equivalency (GED).</p> <p>Primary Crisis Response can only be provided by a QP.</p>

			<p>Paraprofessionals providing this service must be supervised by a qualified professional. Supervision must be provided according to supervision requirements specified in 10A NCAC 27G.0204(b) (c) (f) and according to licensure or certification requirements of the appropriate discipline.</p> <p>Upon enrollment with the PIHP, the organization must have achieved national accreditation with at least one of the designated accrediting agencies.</p> <p>The organization must be established as a legally constituted entity capable of meeting all of the requirements of the PIHP.</p>
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Day Supports Individual-T2021; Group-T2021HQ; Developmental Day-T2027

Day Supports is primarily a group service that provides assistance to the beneficiary with acquisition, retention, or improvement in self-help, socialization and adaptive skills. Day Supports are furnished in a non-residential setting, separate from the home or facility where the beneficiary resides. Day Supports focus on enabling the beneficiary to attain or maintain his or her maximum functional level and is coordinated with any physical, occupational, or speech therapies listed in the Individual Support Plan. Transportation to/from the beneficiary's home, the day supports facility and travel within the community is included. The cost of transportation to and from the day program is included in the payment rate.

Day Supports may include prevocational activities. The following criteria differentiate between prevocational and vocational services:

1. Prevocational services are provided to persons who are not expected to join the general work force or participate in transitional sheltered workshops within one year of service initiation
2. If compensated, the beneficiary may on average, receive less than 50 percent of minimum wage.
3. Services include activities that are not directed at teaching job-specific skills but at underlying rehabilitative goals (e.g. attention span, motor skills, attendance, and task completion.)

Day Supports may not be used for the provision of vocational services (e.g. sheltered workshop preformed in a facility). Vocational services which assist beneficiaries in learning to perform real jobs are to be provided in community settings and not in licensed facilities. Prevocational skills development where beneficiaries obtain the underlying habilitation skills required for obtaining a job may be provided in the licensed day support setting.

Transportation to and from the home of the beneficiary is built into the rate for Day Supports. Time once the beneficiary reaches the licensed day program can be billed to Day Supports. Transportation to and from the licensed day program is the responsibility of the Day Supports provider. If the beneficiary leaves the facility to participate in community programming, the Day Supports authorization includes the time the beneficiary is transported to and from community activities.

Beneficiaries may receive Day Supports outside the facility as long as the outcomes are consistent with the habilitation described in the Individual Support Plan and the service originates from the licensed day program. It is expected that individuals start or end the day at the licensed facility except when the individual attends a community compensatory education program. All licensure categories must be followed and the beneficiary grouping must be appropriate to the age of the beneficiary.

For beneficiaries who are eligible for educational services under the Individuals With Disability Educational Act. Day Supports does not include transportation to/from school settings. This includes transportation to/from the beneficiary's home or any community location where the beneficiary may be receiving services before or after school.

NC Innovations Day Supports Group can be provided with can be provided in a group setting that includes IPRS Day Supports / Activity as long as the NC Innovations definition is met and the staff meet the qualifications of NC Innovations Day Supports Group.

Exclusions	This service may not duplicate services provided under Community Networking, In-Home Intensive Supports, In-Home Skill Building, Residential Supports, Supported Employment and/or one of the State Plan Medicaid Services that works directly with the beneficiary.
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	This service shall not be furnished/billed at the same time of day as Community Networking, In-Home Intensive Supports, In-Home Skill Building, Personal Care Services, Residential Supports, Respite, Supported Employment and/or one of the State Plan Medicaid services that works directly with the person.
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Limits on amount, frequency, or duration	The amount of Day Supports is subject to the Limits on Sets of services. The amount of Day Supports Services also is subject to the amount of person's Support Needs Category Budget if currently phased into the Support Needs Matrix
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Service Delivery Method	<input checked="" type="checkbox"/> Provider Directed <input type="checkbox"/> Individual/Family Directed
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Provider Type	License	Certification	Other Standard
Provider Agencies	NC G.S. 122 C	NC G.S. 122 C	<p>Approved as a provider in the PIHP provider network</p> <p>Agency staff that work with beneficiaries: Are at least 18 years old</p> <p>If providing transportation, have a valid North Carolina driver's license or other valid driver's license, a safe driving record and an acceptable level of automobile liability insurance</p> <p>Criminal background check present no health and safety risk to beneficiary</p> <p>Not listed in the North Carolina Health Care Abuse Registry</p> <p>Qualified in CPR and First Aid</p> <p>Qualified in the customized needs of the beneficiary as described in the ISP.</p> <p>High school diploma or high school equivalency (GED)</p> <p>Paraprofessionals providing this service must be supervised by a qualified professional. Supervision must be provided according to supervision requirements specified in 10A NCAC 27G.0204 (b) (c) (f) and according to licensure or certification requirements of the appropriate discipline.</p> <p>Upon enrollment with the PIHP, the organization must have achieved national accreditation with at</p>

			<p>least one of the designated accrediting agencies.</p> <p>The organization must be established as a legally constituted entity capable of meeting all of the requirements of PIHP</p>
Adult Day Health and Day Care Programs		Certified by NC Division of Aging	<p>Approved as a provider in the PIHP provider network</p> <p>Agency staff that work with beneficiaries: Criminal background check present no health and safety risk to beneficiary</p> <p>Are at least 18 years old</p> <p>If providing transportation, have a valid North Carolina or other valid driver's license, a safe driving record and an acceptable level of automobile liability insurance</p> <p>Not listed in the North Carolina Health Care Abuse Registry</p> <p>Qualified in CPR and First Aid</p> <p>Qualified in the customized needs of the beneficiary as described in the ISP.</p> <p>High school diploma or high school equivalency (GED)</p> <p>Paraprofessionals providing this service must be supervised by a qualified professional. Supervision must be provided according to supervision requirements specified in 10A NCAC 27G.0204 (b) (c) (f) and according to licensure or certification requirements of the appropriate discipline.</p>
Licensed Developmental Day Care Programs	NC G.S. 122 C	NC G.S. 122 C	<p>Approved as a provider in the PIHP provider network</p> <p>Agency staff that work with beneficiaries: Are at least 18 years old</p> <p>If providing transportation, have a valid North Carolina or other valid driver's license, a safe driving record and an acceptable level of automobile liability insurance</p>

		<p>Criminal background check present no health and safety risk to beneficiary</p> <p>Staff that work with beneficiaries must be qualified in the customized needs of the beneficiary as described in the ISP.</p> <p>Not listed in the North Carolina Health Care Abuse Registry</p> <p>Qualified in CPR and First Aid</p> <p>High school diploma or high school equivalency (GED)</p> <p>Paraprofessionals providing this service must be supervised by a qualified professional. Supervision must be provided according to supervision requirements specified in 10A NCAC 27G.0204 (b) (c) (f) and according to licensure or certification requirements of the appropriate discipline.</p> <p>Upon enrollment with the PIHP, the organization must have achieved national accreditation with at least one of the designated accrediting agencies.</p> <p>The organization must be established as a legally constituted entity capable of meeting all of the requirements of PIHP.</p>
<p>Before and After School Day Care Programs Operated by NC Public School System</p>		<p>Approved as a provider in the PIHP provider network</p> <p>Agency staff that work with beneficiaries: Criminal background check present no health and safety risk to beneficiary</p> <p>Are at least 18 years old</p> <p>If providing transportation, have a valid North Carolina or other valid driver's license, a safe driving record and an acceptable level of automobile liability insurance</p>

			<p>Not listed in the North Carolina Health Care Abuse Registry</p> <p>Qualified in CPR and First Aid</p> <p>Qualified in the customized needs of the beneficiary as described in the ISP.</p> <p>High school diploma or high school equivalency (GED)</p> <p>Paraprofessionals providing this service must be supervised by a qualified professional. Supervision must be provided according to supervision requirements specified in 10A NCAC 27G.0204 (b) (c) (f) and according to licensure or certification requirements of the appropriate discipline.</p> <p>Upon enrollment with the PIHP, the organization must have achieved national accreditation with at least one of the designated accrediting agencies.</p> <p>The organization must be established as a legally constituted entity capable of meeting all of the requirements of the PIHP.</p>
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Financial Support Services-T2025-U1 Employer Supplies T2025-U2			
<p>Financial Support Services is the umbrella service for the continuum of supports offered to NC Innovations individuals who elect the Individual and Family Directed Services Option, Employer of Record Model. Financial Support Services are provided to assure that funds for self-directed services are managed and distributed as intended. The service also facilitates employment of support staff by the Employer.</p> <ol style="list-style-type: none"> 1. Filing claims for self-directed services and supports; 2. Payment of payroll to employees hired to provide services and supports; 3. Deducting all required federal, state, and local taxes, including unemployment fees, prior to issuing paychecks to employees; 4. Ordering employment related supplies and paying invoices for other expenses such as training of employees; 5. Administering benefits for employees hired to provide services and supports; 6. Maintaining ledger accounts for each individual's funds; 7. Producing expenditure reports that are required, including reports to the individual/ employer/family, concerning expenditures of funds against their budgets; 8. Requesting criminal background checks, driver's license checks, and health care registry checks of providers of self-directed services; 9. Tracking and monitoring individual budget expenditures; 10. Facilitating Workers Compensation Application on behalf of the Employer of Record; and/or 11. Serving as the Internal Revenue approved Fiscal Employer Agent. 			
Exclusions	The provider of Financial Support Services may only additionally provide Community Guide Services, Community Transition Services, and Individual Goods and Services under the NC Innovations waiver. The Financial Support agency may provide Agency With Choice, community transition and individual goods and services as well as community guide services to the same individual.		
Limits on amount, frequency, or duration	Financial Support Services is considered an "Add On" to the Individual Budget. This service is required of all individuals who elect the Employer of Record Model in the Individual/Family Directed Supports Option.		
Service Delivery Method	<input checked="" type="checkbox"/> Provider Directed <input type="checkbox"/> Individual/Family Directed		
Provider Type	License	Certification	Other Standard
Provider Agencies	Applicable state/local business license		<p>NC G.S. 122C, as applicable</p> <p>Approved as a provider in the PIHP provider network</p> <p>Approved by the Internal Revenue Service to be an employer agent in accordance with Section 3504 of the IRS Code and IRS Revenue Procedure 70-6,</p> <p>Bonded</p> <p>Meets all IRS requirements and be certified by the IRS as an employer agent</p>

			<p>Understands the laws and rules that regulate the expenditure of public funds</p> <p>Able to utilize accounting systems that operate effectively on a large scale as well as track individual budgets</p> <p>Able to develop, implement, and maintain an effective payroll system that adheres to all related tax obligations, both payment and reporting</p> <p>Able to conduct criminal and other required background checks</p> <p>Able to generate service management and statistical information and reports during each payroll cycle</p> <p>Have at least two years of basic accounting and payroll experience</p>
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Home Modifications: S5165

Home Modifications are physical modifications to a private residence that are necessary to ensure the health, welfare, and safety of the beneficiary or to enhance the beneficiary's level of independence. A private residence is a home owned by the beneficiary or his/her family (natural, adoptive, or foster family). Items that are portable may be purchased for use by a beneficiary who lives in a residence rented by the beneficiary or his/her family. This service covers purchases, installation, maintenance, and as necessary, the repair of home modifications required to enable beneficiaries to increase, maintain or improve their functional capacity to perform daily life tasks that would not be possible otherwise. A written recommendation by an appropriate professional is obtained to ensure that the equipment will meet the needs of the beneficiary. A physician's signature certifying medical necessity shall be included with the written request for Home Modifications.

Items that are not of direct or remedial benefit to the beneficiary are excluded from this service. Repair of equipment is covered for items purchased through the waiver or purchased prior to waiver participation, as long as the item is identified within this service definition and the cost of the repair does not exceed the cost of purchasing a replacement piece of equipment. The waiver beneficiary or his/her family must own any equipment that is repaired.

Covered Modifications are:

1. Ramps and Portable Ramps
2. Grab Bars
3. Handrails
4. Lifts, elevators, manual, or other electronic lifts, including portable lifts or lift systems that are used inside a beneficiary's home
5. Porch stair lifts
6. Modifications and/or additions to bathroom facilities
 - a. Roll in shower
 - b. Sink modifications
 - c. Bathtub modifications/grab bars
 - d. Toilet modifications
 - e. Water faucet controls
 - f. Floor urinal and bidet adaptations
 - g. Plumbing modifications
7. Widening of doorways/hallways, turnaround space modifications for improved access and ease of mobility, excluding locks
8. The following specific specialized adaptations:
 - a. Electrical wiring directly related to the modification requested
 - b. Fire safety adaptations related to the modification requested
 - c. Shatterproof windows
 - d. Floor coverings for ease of ambulation for individuals with mobility limitations
 - e. Modifications to meet egress regulations directly related to the modification requested
 - f. Automatic door openers/doorbells
 - g. Voice activated, light activated, motor activated electronic devices to control the beneficiaries home environment
 - h. Medically necessary portable heating and/or cooling adaptation to be limited to one unit per beneficiary

Exclusions	<p>Modification Lists are exhaustive.</p> <p>Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair).</p> <p>Beneficiaries who receive Residential Supports may not receive this service.</p> <p>Central air conditioning; plumbing; swimming pools; service and maintenance contracts and extended warranties are not covered.</p> <p>Equipment or supplies purchased for exclusive use at the school/home school are not covered.</p> <p>Waiver funding will not be used to replace equipment that has not been reasonably cared for and maintained.</p> <p>Home Modifications do not cover new construction (financing of a new home, down payment of a new home, etc.)</p> <p>Items that would normally be available to any child, and are ordinarily provided by the family, are not covered.</p> <p>Locks are not a covered modification.</p>		
Limits on amount, frequency, or duration	<p>The service is limited to expenditures of \$20,000 over the duration of the waiver.</p>		
Service Delivery Method	<p><input checked="" type="checkbox"/> Provider Directed <input type="checkbox"/> Individual/Family Directed</p>		
Provider Type	License	Certification	Other Standard
Specialized Vendors	Applicable state/local business license		<p>All services are provided in accordance with applicable State or local building codes and other regulations.</p> <p>All items must meet applicable standards of manufacture, design, and installation.</p>
Commercial/Retail Businesses	Applicable state/local business license		<p>All services are provided in accordance with applicable State or local building codes and other regulations.</p> <p>All items must meet applicable standards of manufacture, design, and installation.</p>

In-Home Intensive Supports T1015

In- Home Intensive support is available to support beneficiaries in their private home, when the beneficiary needs extensive support and supervision and is only available once the Limits on Sets of Services specified in this waiver have been exhausted. Habilitation, support and/or supervision are provided to assist with positioning, intensive medical needs, elopement and/or behaviors that would result in injury to self or other people. Staff implements interventions and assistance as defined in the ISP. The ISP includes an assessment and a fading plan or plan for obtaining assistive technology to reduce the amount of intensive support needed by the beneficiary.

Authorization Process:

1. In-Home Intensive Supports may only be provided to beneficiaries who have exceptional medical or behavioral support needs on the Supports Intensity Scale ® assessment. Until the beneficiary has a Supports Intensity Scale ® assessment, the NC SNAP is used and the beneficiary must have a score of at least 4 or 5 in Medical and/or Behavioral.
2. In-Home Intensive Support requires prior authorization by PIHP
3. In-Home Intensive Support requires approval by PIHP at a minimum of every 90 days.

These services are provided in the beneficiary’s private home, not in the home of the direct service employee. Beneficiary may receive personal care or community networking outside the private home. These services are not provided in the home or office of a staff person or agency.

Exclusions	<p>This service is not provided to beneficiaries who receive Residential Supports.</p> <p>This service may not be furnished / billed at the same time of day as Day Supports, Community Networking, In-Home Skill Building, Personal Care, Respite, Supported Employment or one of the State Plan Medicaid services that works directly with the person.</p> <p>For beneficiaries who are eligible for educational services under the Individuals With Disability Educational Act, In-home intensive support does not include transportation to/from school settings. This includes transportation to/from the beneficiary’s home, provider home where the beneficiary is receiving services before/after school or any community location where the beneficiary may be receiving services before or after school.</p>
Limits on amount, frequency, or duration	<p>The amount of In Home Intensive Supports is subject to the Limits on Sets of Services. The amount of In Home Intensive Services also is subject to the amount of person’s Support Needs Category Budget if currently phased into the Support Needs Matrix</p>
Service Delivery Method	<p>■ Provider Directed ■ Individual/Family Directed</p>

Provider Type	License	Certification	Other Standard
Employee in a beneficiary-directed arrangement			<p>Staff that work with beneficiary are approved by employer of record or recommended by the Managing Employer and approved by Agency with Choice</p> <p>Staff are at least 18 years old</p> <p>Qualified in CPR and First Aid</p> <p>Qualified in the customized needs of the beneficiary as described in the ISP</p> <p>If providing transportation, have a valid NC driver's license or other valid driver's license, a safe driving record and an acceptable level of automobile liability insurance</p> <p>Criminal background check presents no health and safety risk to beneficiary</p> <p>Not listed in the North Carolina Health Care Abuse Registry</p> <p>High school diploma or equivalency (GED)</p> <p>Supervised by the employer of record or managing employer</p> <p>For service directed by the Agency with Choice, paraprofessionals providing this service must be supervised by a qualified professional. Supervision must be provided according to supervision requirements specified in 10A NCAC 27G.0204 (b) (c) (f) and according to licensure or certification requirements of the appropriate discipline.</p> <p>Employers of Record have an arrangement with an enrolled crisis services provider to respond to beneficiary crisis situations</p> <p>Agency with Choice provides or maintains an agreement with a Crisis Service Provider to respond to beneficiary crisis situations. The beneficiary, however, may select any enrolled Crisis Services provider in lieu of this provider.</p> <p>Agencies with Choice follow State Nursing Board Regulations. State Nursing Board Regulations must be</p>

			<p>followed for tasks that present health and safety risks to the beneficiary as directed by the PIHP Medical Director or Assistant Medical Director.</p> <p>Upon or enrollment with the PIHP, the Agency With Choice must have achieved national accreditation with at least one of the designated accrediting agencies.</p> <p>The Agency With Choice must be established as a legally constituted entity capable of meeting all of the requirements of PIHP.</p>
<p>Provider Agencies</p>			<p>Approved as a provider in the PIHP provider network</p> <p>Agency staff that work with beneficiaries: Are at least 18 years of age</p> <p>If providing transportation, have a valid North Carolina driver's license or other valid driver's license and a safe driving record and has an acceptable level of automobile liability insurance</p> <p>Criminal background check present no health and safety risk to beneficiary</p> <p>Not listed in the North Carolina Health Care Abuse Registry</p> <p>Qualified in CPR and First Aid</p> <p>Qualified in the customized needs of the beneficiary as described in the ISP</p> <p>High school diploma or high school equivalency (GED)</p> <p>Paraprofessionals providing this service must be supervised by a qualified professional. Supervision must be provided according to supervision requirements specified in 10A NCAC 27G.0204 (b) (c) (f) and according to licensure or certification requirements of the appropriate discipline.</p> <p>Enrolled to provide Crisis Services or arrangement with an enrolled Crisis Services Provider to respond to beneficiary crisis situations. The beneficiary, however, may select any enrolled Crisis Services provider in lieu of this provider.</p>

			<p>Upon enrollment with the PIHP, the organization must have achieved national accreditation with at least one of the designated accreditation agencies.</p> <p>The organization must be established as a legally constituted entity, capable of meeting all the requirements of the PIHP.</p>
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In-Home Skill Building Individual-T2013; Group-T2013HQ

In-Home Skill Building provides habilitation and skill building to enable the beneficiary to acquire and maintain skills, which support more independence. In-Home Skill Building augments the family and natural supports of the beneficiary and consists of an array of services that are required to maintain and assist the beneficiary to live in community settings.

In-Home Skill Building consists of:

1. Training in interpersonal skills and development and maintenance of personal relationships
2. Skill building to support the beneficiary in increasing community living skills, such as shopping, recreation, personal banking, grocery shopping and other community activities
3. Training with therapeutic exercises, supervision of self-administration of medication and other services essential to healthcare at home, including transferring, ambulation and use of special mobility devices
4. Transportation to support implementation of in-home skill building

In-Home Skill Building is provided when a primary caregiver is home or when that primary caregiver is regularly scheduled to be absent. In-Home Skill Building is individualized, specific, and consistent with the beneficiary's assessed disability specific needs and is not provided in excess of those needs. In-Home Skill Building is furnished in a manner not primarily intended for the convenience of the beneficiary, primary caregiver, the provider, or the provider/ employer of record. It is anticipated that the presence of in-home skill building will result in a gradual reduction in hours as the individual is trained to take on additional tasks and masters skills (fading plan). This service is distinctive from personal care by the presence of training. The mixture of in-home skill building and personal care must be specified in the Individual Support Plan. It is anticipated that the presence of In-Home Skill Building will result in a gradual reduction in hours as the beneficiary is trained to take on additional tasks and masters skills (fading plan). A formal fading plan is not required.

These services are provided in the beneficiary's private home and not in the home of the direct service employee. In-Home Skill Building Services must start and/or end at the home of the beneficiary.

Exclusions	<p>This service is not provided to beneficiaries who receive Residential Supports.</p> <p>This service may not be furnished / billed at the same time of day as Day Supports, Community Networking, In-Home Intensive Supports, Personal Care Respite, Supported Employment or one of the State Plan Medicaid services that works directly with the person.</p> <p>For beneficiaries who are eligible for educational services under the Individuals With Disability Educational Act, In-Home Skill Building does not include transportation to/from school settings. This includes transportation to/from the beneficiary's home or any other community location where the beneficiary may be receiving services before or after school.</p>
Limits on amount, frequency, or duration	<p>The amount of In Home Skill Building is subject to the Limits on Sets of Services. The amount of In Home Skill Building also is subject to the amount of person's Support Needs Category Budget if currently phased into the Support Needs Matrix.</p>
Service Delivery Method	<p>■ Provider Directed</p> <p>■ Individual/Family Directed</p>

Provider Type	License	Certification	Other Standard
Employee in a beneficiary-directed arrangement			<p>Staff that work with beneficiary are approved by employer of record or recommended by Managing Employer and approved by Agency with Choice</p> <p>Staff are at least 18 years of age</p> <p>If providing transportation, have a valid NC driver's license or other valid driver's license, a safe driving record and an acceptable level of automobile liability insurance</p> <p>Criminal background check presents no health and safety risk to beneficiary</p> <p>Not listed in the North Carolina Health Care Abuse Registry</p> <p>Qualified in CPR and First Aid</p> <p>Qualified in the customized needs of the beneficiary as described in the ISP</p> <p>High school diploma or equivalency (GED)</p> <p>Supervised by the employer of record or managing employer</p> <p>For service directed by the Agency with Choice, paraprofessionals providing this service must be supervised by a qualified professional. Supervision must be provided according to supervision requirements specified in 10A NCAC 27G.0204 (b) (c) (f) and according to licensure or certification requirements of the appropriate discipline.</p> <p>Agencies with Choice follow State Nursing Board Regulations.</p> <p>State Nursing Board Regulations must be followed for tasks that present health and safety risks to the beneficiary as directed by the PIHP Medical Director or Assistant Medical Director</p> <p>Employers of Record have an arrangement with an enrolled crisis services provider to respond to beneficiary crisis situations</p> <p>Upon enrollment with the PIHP, the Agency With Choice must have achieved national accreditation with at least one of the designated accrediting agencies.</p>

		<p>Has an arrangement with an enrolled crisis services provider to respond to beneficiary crisis situations</p> <p>Agency with Choice provides or has an arrangement with an enrolled Crisis Service Provider to respond to beneficiary crisis situations. The beneficiary, however, may select any enrolled Crisis Services provider in lieu of this provider.</p> <p>The Agency With Choice must be established as a legally constituted entity capable of meeting all of the requirements of the PIHP.</p>
<p>Provider Agencies</p>		<p>Approved as a provider in PIHP provider network</p> <p>Agency staff that work with beneficiaries: Are at least 18 years of age</p> <p>If providing transportation, have a valid North Carolina driver's license or other valid driver's license and a safe driving record and has an acceptable level of automobile liability insurance</p> <p>Criminal background check present no health and safety risk to beneficiary</p> <p>Not listed in the North Carolina Health Care Abuse Registry</p> <p>Qualified in CPR and First Aid</p> <p>Staff that work with beneficiaries must be qualified in the customized needs of the beneficiary as described in the ISP.</p> <p>High school diploma or high school equivalency (GED). Paraprofessionals providing this service must be supervised by a qualified professional. Supervision must be provided according to supervision requirements specified in 10A NCAC 27G.0204 (b) (c) (f) and according to licensure or certification requirements of the appropriate discipline.</p> <p>Upon enrollment with the PIHP, the organization must have achieved national accreditation with at least one of the designated accreditation agencies.</p> <p>Enrolled to provide Crisis Services or arrangement with an enrolled Crisis Services Provider to respond to beneficiary crisis situations. The beneficiary, however, may select any enrolled Crisis Services provider in lieu of this provider.</p> <p>The organization must be established as a legally constituted entity, capable of meeting all the requirements of the PIHP.</p>

Individual Goods and Services: T1999			
<p>Individual Goods and Services are services, equipment or supplies not otherwise provided through this waiver or through the Medicaid State Plan that address an identified need in the Individual Support Plan (including improving and maintaining the beneficiary’s opportunities for full membership in the community) and meet the following requirements:</p> <ol style="list-style-type: none"> 1. the item or service would decrease the need for other Medicaid services; AND/OR 2. promote inclusion in the community; AND/OR 3. increase the beneficiary’s safety in the home environment; AND 4. the beneficiary does not have the funds to purchase the item or service. 			
Exclusions	Individual Goods and Services do not include experimental goods and services inclusive of items which may be defined as restrictive under NC G.S. 122C-60. This service is available only to beneficiaries who self-direct at least one of their services.		
Limits on amount, frequency, or duration	The cost of individual directed goods and services for each beneficiary cannot exceed \$2,000.00 per beneficiary plan year annually.		
Service Delivery Method	<input type="checkbox"/> Provider Directed <input checked="" type="checkbox"/> Individual/Family Directed		
Provider Type	License	Certification	Other Standard
Employee in a beneficiary-directed arrangement			<p>Staff that work with beneficiaries are approved by employer of record or recommended by Managing Employer and approved by Agency with Choice</p> <p>If providing transportation, have a valid North Carolina or other valid driver’s license, a safe driving record and an acceptable level of automobile liability insurance</p> <p>Criminal background check present no health and safety risk to beneficiary</p> <p>Are at least 18 years old</p> <p>Not listed in the North Carolina Health Care Abuse Registry</p> <p>High school diploma or equivalency (GED) Supervised by the employer of record or managing employer</p> <p>Qualified in CPR and First Aid</p> <p>Qualified in the customized needs of the beneficiary as described in the ISP</p>

			<p>For service directed by the Agency with Choice, paraprofessionals providing this service must be supervised by a qualified professional. Supervision must be provided according to supervision requirements specified in 10A NCAC 27G.0204 (b) (c) (f) and according to licensure or certification requirements of the appropriate discipline.</p> <p>State Nursing Board Regulations must be followed for tasks that present health and safety risks to the beneficiary as directed by THE PIHP Medical Director or Assistant Medical Director</p> <p>Agencies with Choice follow State Nursing Board Regulations.</p> <p>Upon enrollment with the PIHP, the Agency with Choice must have achieved national accreditation with at least one of the designated accrediting agencies.</p> <p>The Agency with Choice must be established as a legally constituted entity capable of meeting all of the requirements of the PIHP</p>
Commercial/ Retail Businesses	Applicable state/local business license		Meets applicable state and local requirements for type of item that the vendor is providing
Agency With Choice			<p>Agency enrolled with PIHP</p> <p>NC G.S.122C, as applicable</p> <p>Meets applicable state and local requirements for type of item that the vendor is providing</p>
Financial Support- Agency			<p>Agency enrolled with PIHP</p> <p>NC G.S.122C, as applicable</p> <p>Meets applicable state and local requirements for type of item that the vendor is providing</p>

Natural Supports Education: Individual-S5110; Conference-S5111

Natural Supports Education provides training to families and the beneficiary’s natural support network in order to enhance the decision making capacity of the natural support network, provide orientation regarding the nature and impact of the intellectual and other developmental disabilities upon the beneficiary, provide education and training on intervention/strategies, and provide education and training in the use of specialized equipment and supplies. The requested education and training must have outcomes directly related to the needs of the beneficiary or the natural support network’s ability to provide care and support to the beneficiary. In addition to individualized natural support education, reimbursement will be made for enrollment fees and materials related to attendance at conferences and classes by the primary caregiver. The expected outcome of this training is to develop and support greater access to the community by the beneficiary by strengthening his or her natural support network.

Exclusions	<p>The cost of transportation, lodging, and meals are not included in this service.</p> <p>Natural Supports Education excludes training furnished to family members through Specialized Consultation Services.</p> <p>Training and education, including reimbursement for conferences, are excluded for family members and natural support networks when those members are employed to provide supervision and care to the beneficiary.</p>
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Limits on amount, frequency, or duration	Reimbursement for conference and class attendance will be limited to \$1,000 per year.
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Service Delivery Method	<ul style="list-style-type: none"> ■ Provider Directed ■ Individual/Family Directed
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Provider Type	License	Certification	Other Standard
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Employee in a beneficiary-directed arrangement			<p>Staff are approved by employer of record or recommended by Managing Employer and approved by Agency with Choice and are:</p> <p>Are at least 18 years old</p> <p>The Criminal Background Check presents no risk to the beneficiary</p> <p>Not listed in the North Carolina Health Care Abuse Registry.</p> <p>If providing transportation, have a valid North Carolina or other valid driver’s license, a safe driving record and an acceptable level of automobile liability insurance</p> <p>Qualified in CPR and First Aid</p>
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		<p>Has expertise as appropriate in the field in which the training is provided as identified in the Individual Support Plan</p> <p>Qualified Professional as specified in 10A NCAC 27G.0204 (b) (c) (f) and according to licensure or certification requirements of the appropriate discipline.</p> <p>Supervised by the employer of record or Managing Employer</p> <p>Qualified in the customized needs of the beneficiary as described in the Individual Support Plan</p> <p>Agencies with Choice follow the NC State Nursing Board regulations.</p> <p>State Nursing Board Regulations must be followed for tasks that present health and safety risks to the beneficiary as directed by THE PIHP Medical Director or Assistant Medical Director.</p> <p>Upon enrollment with the PIHP, the Agency with Choice must have achieved national accreditation with at least one of the designated accrediting agencies.</p> <p>The Agency with Choice must be established as a legally constituted entity capable of meeting all of the requirements of the PIHP. Has expertise as appropriate in the field in which the training is provided in the ISP</p>
<p>Provider Agencies</p>		<p>Approved as a provider in the PIHP provider network</p> <p>Agency staff that work with beneficiaries:</p> <p>Are at least 18 years old</p> <p>Criminal background check presents no health and safety risk to beneficiary</p> <p>Not listed in the North Carolina Health Care Abuse Registry.</p> <p>If providing transportation, have a valid North Carolina or other valid driver's license, a safe driving record and an acceptable level of automobile liability insurance</p> <p>Qualified professional as specified in 10A NCAC 27G.0204 and according to licensure or certification requirements of the appropriate discipline.</p>

			<p>Qualified in CPR and First Aid</p> <p>Has expertise as appropriate in the field in which the training is provided in the ISP.</p> <p>Qualified in the customized needs of the beneficiaries as described in the Individual Support Plan</p> <p>Upon enrollment with the PIHP, the organization must have achieved national accreditation with at least one of the designated accrediting agencies.</p> <p>The organization must be established as a legally constituted entity capable of meeting all of the requirements of the PIHP.</p>
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Personal Care Services S5125

Personal Care Services under North Carolina State Medicaid Plan differs in service definition and provider type from the services offered under the waiver. Personal Care Services under the waiver include support, supervision and engaging participation with eating, bathing, dressing, personal hygiene and other activities of daily living. Support and engaging the beneficiary describes the flexibility of activities that may encourage the beneficiary to maintain skills gained during habilitation while also providing supervision for independent activities. This service may include preparation of meals, but does not include the cost of the meals themselves.

When specified in the ISP, this service may also include housekeeping chores such as bed making, dusting and vacuuming, which are incidental to the care furnished or which are essential to the health and welfare of the beneficiary, rather than the beneficiary’s family. Personal care also includes assistance with monitoring health status and physical condition, assistance with transferring, ambulation, and use of special mobility devices.

Personal Care Services may be provided outside of the private home as long as the outcomes are consistent with the support described in the ISP. Services may be allowed in the private home of the provider, staff or an Employer of Record, or staff of an Agency With Choice if there is documentation in the ISP that the beneficiary’s needs cannot be met in the beneficiary’s private home or another community location.

Exclusions	<p>Personal Care Services do not include medical transportation and may not be provided during medical transportation and medical appointments.</p> <p>Beneficiaries, who live in licensed residential facilities, licensed AFL homes, licensed foster homes, or unlicensed alternative family living homes serving one adult, may not receive any aspect of this service or any other State Plan Personal Care Service.</p> <p>Personal Care cannot be provided in a licensed program.</p> <p>This service may not be provided on the same day that the beneficiary receives State Plan Medicaid Personal Care Services, a home health aide visit, Residential Supports or another substantially equivalent service.</p> <p>This service may not be provided at the same time of day that a beneficiary receives Day Supports, Community Networking, In-Home Intensive Support, In-Home Skill Building, and Respite, Supported Employment or one of the State Plan Medicaid services that works directly with the person.</p> <p>The service does not cover the staff member completing home maintenance, housekeeping for areas that are used by other members of the household and/or meal preparation when the same meal is being prepared for other family members.</p> <p>For beneficiaries who are eligible for educational services under the Individuals With Disability Educational Act, personal care does not include transportation to/from school settings. This includes transportation to/from the beneficiary’s home, provider home where the beneficiary may be receiving services before or after school or any other community location where the beneficiary may be receiving services before or after school.</p>
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	Transportation between the beneficiary's home and the provider's home is not billable service time.		
Limits on amount, frequency, or duration	The amount of Personal Care Services is subject to the limits on sets of services. The amount of Personal Care Services also is subject to the amount of person's Support Needs Category Budget if currently phased into the Support Needs Matrix.		
Service Delivery Method	<ul style="list-style-type: none"> ■ Provider Directed ■ Individual/Family Directed 		
Provider Type	License	Certification	Other Standard
Employee in a beneficiary-directed arrangement			<p>Staff that work with beneficiary are approved by employer of record or recommended by the Managing Employer and approved by Agency with Choice</p> <p>Staff are at least 18 years of age</p> <p>If providing transportation, have valid NC driver's license or other valid driver's license, a safe driving record an acceptable level of automobile liability insurance</p> <p>Criminal background check presents no health and safety risk to beneficiary</p> <p>Not listed in NC Health Care Abuse Registry</p> <p>Qualified in CPR and First Aid</p> <p>Qualified in the customized needs of the beneficiary as described in the ISP</p> <p>High school diploma or equivalency (GED) and supervised by the Employer of Record</p> <p>Supervised by the employer of record or managing employer</p> <p>For service directed by the Agency with Choice, paraprofessionals providing this service must also be supervised by a qualified professional. Supervision must be provided according to supervision requirements specified in 10A NCAC 27G.0204 (b) (c) and (f) and according to licensure or certification requirements of the appropriate discipline.</p> <p>Agencies with Choice follow State Nursing Board Regulations.</p>

			<p>State Nursing Board regulations must be followed for tasks that present health and safety risks to the beneficiary as directed by the PIHP Medical Director or Assistant Medical Director</p> <p>The Agency With Choice must be established as a legally constituted entity capable of meeting all of the requirements of the PIHP.</p> <p>Upon enrollment as a provider, the Agency With Choice must have achieved national accreditation with at least one of the designated accrediting agencies.</p> <p>Employers of Record have an arrangement with an enrolled crisis services provider to respond to beneficiary crisis situations</p> <p>Agency with Choice provides or maintains an agreement with a Crisis Service Provider to respond to beneficiary crisis situations. The beneficiary, however, may select any enrolled Crisis Services provider in lieu of this provider.</p> <p>Services provided in the private home of the direct service employee are subject to the PIHP Health and Safety assurances checklist and monthly monitoring by the Employer of Record or Agency With Choice qualified professional</p>
Home Health Agency	Licensed by the Division of Health Service Regulation as a Home Care Agency		<p>Approved as a provider in PIHP provider network</p> <p>Agency staff that work with beneficiaries: Are at least 18 years of age</p> <p>If providing transportation, have a valid North Carolina driver's license or other valid driver's license and a safe driving record and has an acceptable level of automobile liability insurance Criminal background check present no health and safety risk to beneficiary</p> <p>Not listed in the North Carolina Health Care Abuse Registry</p> <p>Qualified in CPR and First Aid and the</p> <p>Qualified in the customized needs of the beneficiary as described in the ISP</p>

			<p>High school diploma or high school equivalency (GED)</p> <p>Paraprofessionals providing this service must be supervised by a qualified professional. Supervision must be provided according to supervision requirements specified in 10A NCAC 27G.0204 (b) (c) (f) and according to licensure or certification requirements of the appropriate discipline.</p> <p>Enrolled to provide Crisis Services or arrangement with an enrolled Crisis Services Provider to respond to beneficiary crisis situations. The beneficiary, however, may select any enrolled Crisis Services provider in lieu of this provider.</p> <p>Upon enrollment with the PIHP, the organization must have achieved national accreditation with at least one of the designated accreditation agencies.</p> <p>The organization must be established as a legally constituted entity, capable of meeting all the requirements of the PIHP.</p> <p>Services provided in the private home of the direct service employee are subject to the PIHP Health and Safety assurances checklist and <u>monthly monitoring by the provider agency.</u></p>
<p>Personal Care Service Provider Agency</p>			<p>Approved as a provider in the PIHP provider network</p> <p>Agency staff that work with beneficiaries: Are at least 18 years of age</p> <p>If providing transportation, have a valid North Carolina driver's license or other valid driver's license and a safe driving record and has an acceptable level of automobile liability insurance</p> <p>Criminal background check present no health and safety risk to beneficiary</p> <p>Not listed in the North Carolina Health Care Abuse Registry</p> <p>Qualified in CPR and First Aid</p>

			<p>Qualified in the customized needs of the beneficiary as described in the ISP</p> <p>High school diploma or high school equivalency (GED)</p> <p>Paraprofessionals providing this service must be supervised by a Qualified Professional</p> <p>Supervision must be provided according to supervision requirements specified in 10A NCAC 27G.0204 (b) (c) (f) and according to licensure or certification requirements of the appropriate discipline.</p> <p>Enrolled to provide Crisis Services or arrangement with an enrolled Crisis Services Provider to respond to beneficiary crisis situations. The individual, however, may select any enrolled Crisis Services provider in lieu of this provider.</p> <p>Upon enrollment with the PIHP, the organization must have achieved national accreditation with at least 1 of designated accreditation agencies.</p> <p>The organization must be established as a legally constituted entity, capable of meeting all the requirements of PIHP.</p> <p>Services provided in the private home of the direct service employee are subject to the PIHP Health and Safety assurances checklist and monthly monitoring by the Employer of Record or provider agency.</p>
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Residential Supports: Level 1 and Level 1 AFL-H2016; Level 2 and Level 2 AFL-T2014; Level 3 and Level 3 AFL-T2020; Level 4 and Level 4 AFL-H2016H1

Residential Supports consist of an integrated array of individually designed training activities, assistance and supervision.

Residential Supports include:

1. Habilitation Services aimed at assisting the beneficiary to acquire, improve, and retain skills in self-help, general household management and meal preparation, personal finance management, socialization and other adaptive areas. Training outcomes focus on allowing the beneficiary to improve his/her ability to reside as independently as possible in the community.
2. Assistance in activities of daily living when the beneficiary is dependent on others to ensure health and safety.
3. Habilitation services that allow the beneficiary to participate in home life or community activities. Transportation to and from the residence and points of travel in the community is included to the degree that they are not reimbursed by another funding source.

Residential Supports are provided to individuals who live in a community residential setting that meets the home and community based characteristics as outlined in Appendix C of the Innovations Waiver document.

1. Facility capacity for all newly developed facilities, approved within the PIHP network and that meet the home and community based characteristics is three beds or less.
2. Facility capacity for existing facilities approved within the PIHP network and meeting the home and community based characteristics, is six beds or less.
3. Facilities that meet the home and community based characteristics, and currently serve a waiver beneficiary, larger than six beds which meet HCBS characteristics as defined in this waiver will be allowed to continue to provide Residential Supports until the waiver beneficiary is discharged from the facility.

No new waiver beneficiaries will be admitted to a facility larger than 6 beds.

Residential Supports may additionally be provided in an AFL situation. The site must be the primary residence of the AFL provider (includes couples and single persons) who receive reimbursement for the cost of care. These sites are licensed or unlicensed in accordance with state rule. All AFL sites will be reviewed using the PIHP AFL checklist for health and safety related issues.

Home and community environment is described in the Location of Services.

Residential Supports daily rates include payments for relief staff that provide support for the beneficiary in the group home or alternative family living home. Relief staff is provided in the beneficiary's residence and is not provided in a different residential setting.

The NC SNAP is used to determine Residential Support Levels in areas where the Supports Intensity Scale ® has not been fully implemented. Levels and corresponding NC SNAP scores are:

- Level 1: SNAP Index 24-44
- Level 2: SNAP Index 45-79
- Level 3: SNAP Index 80-94
- Level 4: SNAP Index 95-230

Exclusions	<p>Transportation to/from a child's school is the responsibility of the school system rather than the Residential Supports Provider.</p> <p>Transportation to/from medical appointments is billed to State Medicaid Plan Transportation rather than Residential Supports.</p> <p>Beneficiaries who receive Residential Supports may not receive Home Modifications, In-Home Intensive Supports, In-Home Skill Building, Personal Care Services, Respite, Vehicle Modifications, or State Plan Personal Care Services.</p> <p>This service is not available at the same time of day as Community Networking, Day Supports, Supported Employment or one of the State Plan Medicaid services that works directly with the person.</p> <p>Payments for Residential Supports do not include payments for room and board, the cost of facility maintenance and upkeep.</p>		
Limits on amount, frequency, or duration	<p>The amount of Residential Supports is subject to the Limits on Sets of Services. The amount of Residential Support Services is also subject to the amount of person's Support Needs Category Budget if currently phased into the Support Needs Matrix.</p>		
Service Delivery Method	<p><input checked="" type="checkbox"/> Provider Directed <input type="checkbox"/> Individual/Family Directed</p>		
Provider Type	License	Certification	Other Standard
<p>Supervised Living facilities 3 beds or less for newly developed facilities; 6 beds or less for existing facilities except that any facility licensed on June 15, 2001 for more than six clients at that time may be grandfathered at no more than the facility's licensed capacity.</p> <p>Supervised Living facilities 3 beds or less for newly developed facilities; 6 beds or less for</p>	<p>10 A NCAC 27G.5600, statutory authority: NC General Statute 143B-147 Type: B</p> <p>10 A NCAC 27G.5600, statutory</p>		<p>Approved as a provider in the PIHP provider network</p> <p>Agency staff that work with beneficiaries: Are at least 18 years old</p> <p>If providing transportation, have a valid North Carolina or other valid driver's license, a safe driving record and an acceptable level of automobile liability insurance</p> <p>Criminal background check presents no health and safety risk to beneficiary</p> <p>Not listed in the North Carolina Health Care Abuse Registry</p> <p>Qualified in CPR and First Aid</p> <p>High school diploma or high school equivalency (GED)</p> <p>Paraprofessionals providing this service must be supervised by a Qualified Professional</p>

<p>existing facilities except that any facility licensed on June 15, 2001 for more than six clients at that time may be grandfathered at no more than the facility's licensed capacity.</p>	<p>authority: NC General Statute 143B-147 Type: C</p>		<p>Supervision must be provided according to supervision requirements specified in 10A NCAC 27G.0204 (b) (c) (f) and according to licensure or certification requirements of the appropriate discipline.</p> <p>Qualified in the customized needs of the beneficiary as described in the ISP.</p> <p>Upon enrollment with the PIHP, the organization must have achieved national accreditation with at least one of the designated accrediting agencies.</p> <p>The organization must be established as a legally constituted entity capable of meeting all of the requirements of the PIHP.</p> <p>Enrolled to provide Crisis Services or has an arrangement with an enrolled Crisis Services Provider to respond to beneficiary crisis situations. The Beneficiary may select any enrolled Crisis Services provider in lieu of this provider however.</p>
<p>Supervised living facilities type F serve no more than 3 minors or 3 adults with a developmental disability</p> <p>Unlicensed supervised living homes may only serve one adult based on 10A NCAC 27 G.5601 (b) (1) (2)</p>	<p>NC G.S. 122 C10 A NCAC 27G.5600, statutory authority: NC General Statute 143B-147 Type: F</p> <p>NA</p>		<p>Approved as a provider in the PIHP provider network</p> <p>Agency staff that work with beneficiaries: Are at least 18 years old</p> <p>Not listed in the North Carolina Health Care Abuse Registry</p> <p>Criminal background check presents no health and safety risk to beneficiary</p> <p>If providing transportation, have a valid North Carolina driver's license, a safe driving record and an acceptable level of automobile liability insurance</p> <p>Not listed in the North Carolina Health Care Abuse Registry</p>

			<p>Qualified in CPR and First Aid</p> <p>Staff that work with beneficiaries must be qualified in the customized needs of the beneficiary as described in the ISP.</p> <p>High school diploma or high school equivalency (GED)</p> <p>Paraprofessionals providing this service must be supervised by a Qualified Professional.</p> <p>Supervision must be provided according to supervision requirements specified in 10A NCAC 27G.0204 (b) (c) (f) and according to licensure or certification requirements of the appropriate discipline.</p> <p>Enrolled to provide Crisis Services or has an arrangement with an enrolled Crisis Services Provider to respond to beneficiary crisis situations. The Beneficiary may select any enrolled Crisis Services provider in lieu of this provider however.</p> <p>Site must be the primary residence of the AFL provider (includes couples and single persons) who receive reimbursement for cost of care.</p> <p>Upon enrollment with the PIHP, the organization must have achieved national accreditation with at least one of the designated accrediting agencies.</p> <p>The organization must be established as a legally constituted entity capable of meeting all of the requirements of THE PIHP.</p> <p>Back-up staff must be employees of the agency.</p>
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Respite: Individual-S5150; Group-S5150HQ; Nursing Respite, RN-T1005TD; Nursing Respite, LPN- T1005TE; Facility-S5150US

Respite services provide periodic support and relief to the primary caregiver(s) from the responsibility and stress of caring for the beneficiary. This service enables the primary caregiver to meet or participate in planned or emergency events, and to have planned time for him/her and/or family members. Respite may be utilized during school hours for sickness or injury. Respite may include in and out-of-home services, inclusive of overnight, weekend care, or emergency care (family emergency based, not to include out of home crisis). The primary caregiver is the person principally responsible for the care and supervision of the beneficiary and must maintain his/her primary residence at the same address as the beneficiary.

Exclusions

This service may not be used as a daily service in individual support. This service is not available to beneficiaries who receive Residential Supports and/or those who live in licensed residential settings or Alternative Family Living Homes. Staff sleep time is not reimbursable. Respite services are only provided for the beneficiary; other family members, such as siblings of the beneficiary, may not receive care from the provider while Respite Care is being provided/billed for the beneficiary. Respite Care is not provided by any beneficiary who resides in the beneficiary's primary place of residence. FFP will not be claimed for the cost of room and board except when provided, as part of respite care furnished in a facility approved by the State that is not a private residence.

For beneficiaries who are eligible for educational services under Individual's With Disability Educational Act, Respite does not include transportation to/from school settings. This includes transportation to/from beneficiary's home, provider home where the beneficiary is receiving services before/after school or any community location where the beneficiary may be receiving services before or after school.

Respite may not be used for beneficiaries who are living alone or with a roommate; staff sleep time is not reimbursable.

This service is not available at the same time of day as Community Networking, Day Supports, In-Home Intensive Supports, In-Home Skill Building, Personal Care, Supported Employment or one of the State Plan Medicaid Services that works directly with the person such as Private Duty Nursing.

Limits on amount, frequency, or duration

The cost of 24 hours of respite care cannot exceed the per diem rate for the average community ICF-IID Facility. The amount of Respite Services is subject to the amount of person's Support Needs Category Budget if currently phased into the Support Needs Matrix.

Service Delivery Method

- **Provider Directed**
- **Individual/Family Directed**

Provider Type	License	Certification	Other Standard
Employee in a beneficiary-directed arrangement		NC G.S. 122 C, as applicable	<p>Approved by Employer of Record or recommended by Managing Employer and approved by Agency with Choice</p> <p>At least 18 years old</p> <p>If providing transportation, have a valid North Carolina or other valid driver’s license, a safe driving record and an acceptable level of automobile liability insurance</p> <p>Criminal background check presents no health and safety risk to beneficiary</p> <p>Supervised by the employer of record or managing employer</p> <p>Not listed in the North Carolina Health Care Abuse Registry</p> <p>Qualified in CPR and First Aid</p> <p>Staff that work with beneficiaries must be qualified in the customized needs of the beneficiary as described in the ISP</p> <p>Staff that work with beneficiaries must have a high school diploma or high school equivalency (GED)</p> <p>For service directed by the Agency with Choice, paraprofessionals providing this service must be supervised by a qualified professional. Supervision must be provided according to supervision requirements specified in 10A NCAC 27G.0204 (b) (c) (f) and according to licensure or certification requirements of the appropriate discipline.</p> <p>State Nursing Board Regulations must be followed for tasks that present health and safety risks to the beneficiary as directed by the PIHP Medical Director or Assistant Medical Director</p>

			<p>If providing Nursing Respite, must be a Licensed RN or Licensed LPN in North Carolina</p> <p>Agencies with Choice follow State Nursing Board Regulations</p> <p>Upon enrollment with the PIHP, the Agency With Choice must have achieved national accreditation with at least one of the designated accrediting agencies.</p> <p>The Agency With Choice must be established as a legally constituted entity capable of meeting all the requirements of the PIHP.</p> <p>Services provided in the home of the direct service employees are subject to the checklist and monthly monitoring by the Agency With Choice qualified professional or the Employer of Record</p>
<p>Provider Agencies, facility based and in-home services</p>	<p>NC G.S. 122 C</p>	<p>NC G.S. 122 C</p>	<p>Approved as a provider in the PIHP provider network</p> <p>Agency staff that work with beneficiaries: Are at least 18 years of age</p> <p>Criminal background check presents no health and safety risk to beneficiary</p> <p>If providing transportation, have a valid North Carolina driver's license, a safe driving record and an acceptable level of automobile liability insurance</p> <p>Not listed in the North Carolina Health Care Abuse Registry</p> <p>Qualified in CPR and First Aid the</p> <p>Qualified in the customized need of the beneficiaries as described in the Individual Support Plan</p> <p>High school diploma or high school equivalency (GED).</p>

			<p>Paraprofessionals providing this service must be supervised by a qualified professional. Supervision must be provided according to supervision requirements specified in 10A NCAC 27G.0204 (b) (c) (f) and according to licensure or certification requirements of the appropriate discipline.</p> <p>If providing Nursing Respite, must be a Licensed RN or Licensed LPN in North Carolina.</p> <p>Services provided in the private home of the direct service employee are subject to the checklist and monthly monitoring by the qualified professional.</p> <p>Upon enrollment with the PIHP, the organization must have achieved national accreditation with at least one of the designated accrediting agencies.</p> <p>The organization must be established as a legally constituted entity capable of meeting all of the requirements of the PIHP.</p>
<p>Provider Agencies who operate private respite homes</p>	<p>Private home respite services serving individuals outside their private homes are subject to licensure under NC G.S. 122C Article 2 when: more than two individuals are served concurrently, or either one or two children, two adults, or any combination thereof are served for a cumulative period of time exceeding 240 hours per calendar</p>	<p>NC G.S. 122 C</p>	<p>Approved as a provider in the PIHP provider network</p> <p>Agency staff that work with beneficiaries: Are at least 18 years old</p> <p>If providing transportation, have a valid North Carolina or other valid driver's license, a safe driving record and an acceptable level of automobile liability insurance</p> <p>Criminal background check presents no health and safety risk to beneficiary</p> <p>Not listed in the North Carolina Health Care Abuse Registry</p> <p>Qualified in CPR and First Aid</p> <p>Qualified in the customized needs of the beneficiary as described in the ISP</p> <p>High school diploma or high school equivalency (GED)</p>

	month.		<p>Paraprofessionals providing this service must be supervised by a qualified professional. Supervision must be provided according to supervision requirements specified in 10A NCAC 27G.0204 (b) (c) (f) and according to licensure or certification requirements of the appropriate discipline.</p> <p>Upon enrollment with the PIHP, the organization must have achieved national accreditation with at least one of the designated accrediting agencies.</p> <p>The organization must be established as a legally constituted entity capable of meeting all of the requirements of the PIHP</p> <p>Services provided in the private home of the direct service employee are subject to the checklist and monthly monitoring by the qualified professional</p>
Nursing Respite, Provider Agencies		NC G.S. 122 C	<p>Approved as a provider in the PIHP provider network</p> <p>Agency staff that work with beneficiaries: Are at least 18 years old Provided by an RN or LPN licensed in the State of North Carolina</p> <p>If providing transportation, have a valid North Carolina or other valid driver's license, a safe driving record and an acceptable level of automobile liability insurance</p> <p>Criminal background check presents no health and safety risk to beneficiary</p> <p>Not listed in the North Carolina Health Care Abuse Registry.</p> <p>Qualified in CPR and First Aid</p> <p>Staff that work with beneficiaries must be qualified in the customized needs of the beneficiary as described in the ISP</p>

			<p>Staff that work with beneficiaries must have a high school diploma or high school equivalency (GED)</p> <p>Paraprofessionals providing this service must be supervised by a qualified professional. Supervision must be provided according to supervision requirements specified in 10A NCAC 27G.0204 (b) (c) (f) and according to licensure or certification requirements of the appropriate discipline.</p> <p>Upon enrollment with the PIHP, the organization must have achieved national accreditation with at least one of the designated accrediting agencies.</p> <p>The organization must be established as a legally constituted entity capable of meeting all of the requirements of the PIHP.</p> <p>Services provided in the private home of the direct service employee are subject to the checklist and monthly monitoring by the qualified professional</p>
<p>Nursing Respite Home Care Agencies</p>	<p>Licensed by the NC DHHS, Division of Health Services Regulation in accordance with NCGS 131E, Article 6, Part C</p>		<p>NC G.S. 122C, as applicable</p> <p>Approved as a provider in the PIHP provider network</p> <p>Agency staff that work with beneficiaries: Are at least 18 years old</p> <p>Staff that work with beneficiaries must have a high school diploma or high school equivalency (GED); Nursing Respite is provided by an RN or LPN licensed in the State of North Carolina</p> <p>If providing transportation, have a valid North Carolina or other valid driver's license, a safe driving record and an acceptable level of automobile liability insurance</p> <p>Criminal background check presents no health and safety risk to beneficiary</p>

			<p>Not listed in the North Carolina Health Care Abuse Registry</p> <p>Qualified in CPR and First Aid</p> <p>Qualified in the customized needs of the beneficiary as described in the ISP</p> <p>Paraprofessionals providing this service must be supervised by a qualified professional. Supervision must be provided according to supervision requirements specified in 10A NCAC 27G.0204 (b) (c) (f) and according to licensure or certification requirements of the appropriate discipline.</p> <p>Upon enrollment with the PIHP, the organization must have achieved national accreditation with at least one of the designated accrediting agencies.</p> <p>The organization must be established as a legally constituted entity capable of meeting all of the requirements of the PIHP.</p> <p>Services provided in the private home of the direct service employee are subject to the checklist and monthly monitoring by the qualified professional</p>
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Specialized Consultation Services: T2025; BCBA T2025 HO

Specialized Consultation Services provide expertise, training and technical assistance in a specialty area (psychology, behavior intervention, speech therapy, therapeutic recreation, augmentative communication, assistive technology equipment, occupational therapy, physical therapy or nutrition) to assist family members, support staff and other natural supports in assisting beneficiaries with developmental disabilities who have long term intervention needs. Under this model, family members and other paid/unpaid caregivers are trained by a certified, licensed, and/or registered professional, or qualified assistive technology professional to carry out therapeutic interventions, consistent with the Individual Support Plan, therefore increasing the effectiveness of the specialized therapy. This service will also be utilized to allow specialists defined to be an integral part of the Individual Support Team to participate in team meetings and provide additional intensive consultation and support for beneficiaries whose medical and/or behavioral /psychiatric needs are considered to be extreme or complex. The beneficiary may or may not be present during service provision. The professional and support staff are able to bill for their service time concurrently.

Activities covered are:

1. Observing the beneficiary to determine needs;
2. Assessing any current interventions for effectiveness;
3. Developing a written intervention plan, which may include recommendations for assistive technology/equipment, home modifications, and vehicle adaptations;
4. Intervention plan will clearly delineate the interventions, activities and expected outcomes to be carried out by family members, support staff and natural supports;
5. Training of relevant persons to implement the specific interventions/support techniques delineated in the intervention plan and to observe, record data and monitor implementation of therapeutic interventions/support strategies;
6. Reviewing documentation and evaluating the activities conducted by relevant persons as delineated in the intervention plan with revision of that plan as needed to assure progress toward achievement of outcomes;
7. Training and technical assistance to relevant persons to instruct them on the implementation of the beneficiary's intervention plan;
8. Participating in team meetings; and/or
9. Tele-consultation through use of two-way, real time-interactive audio and video between places of lesser and greater clinical expertise to provide behavioral and psychological care when distance separates the care from the beneficiary.

Exclusions	Specialized Consultative Services excludes services provided through Natural Supports Education and Crisis Services. This service may not duplicate services provided to family members through natural supports education.
Limits on amount, frequency, or duration	Specialized consultation services exclude services provided through natural supports education and crisis services.
Service Delivery Method	<input checked="" type="checkbox"/> Provider Directed <input type="checkbox"/> Individual/Family Directed

Provider Type	License	Certification	Other Standard
Independent Practitioners	Licensure specific to discipline, if applicable	Certification or registration specific to discipline, if applicable	<p>NC G.S.122C, as appropriate</p> <p>Approved by the PIHP</p> <p>At least 18 years old</p> <p>Criminal background check presents no health and safety risk to beneficiary</p> <p>Not listed in the North Carolina Health Care Abuse Registry</p> <p>Qualified in the customized need of the beneficiaries as described in the Individual Support Plan</p> <p>Staff must hold appropriate NC license for physical therapy, occupational therapy, speech therapy, psychology and nutrition; board certified behavior analyst –MA; master’s degree and expertise in augmentative communication ;state certification in assistive technology and state certification in recreation therapy</p>
Provider Agencies			<p>NC G.S.122C, as appropriate</p> <p>Approved as a provider in the PIHP provider network</p> <p>Agency staff that work with beneficiaries: At least 18 years old</p> <p>Criminal background check presents no health and safety risk to beneficiary</p> <p>Not listed in the North Carolina Health Care Abuse Registry</p> <p>Qualified in the customized needs of the beneficiary as described in the Individual Support Plan</p> <p>Staff must hold appropriate NC license for physical therapy, occupational therapy, speech therapy, psychology and nutrition; state certification for recreational therapy; board certified behavior analyst-MA; master’s degree and expertise in augmentative communication; state certification in assistive technology.</p>

Supported Employment Services: Individual-H2025; Group-H2025HQ

Supported Employment Services provide assistance with choosing, acquiring, and maintaining a job for beneficiaries ages 16 and older for whom competitive employment has not been achieved and /or has been interrupted or intermittent.

Initial Supported Employment services include:

1. Pre-job training/education and development activities to prepare a person to engage in meaningful work-related activities which may include career/educational counseling, job shadowing, assistance in the use of educational resources, training in resume preparation, job interview skills, study skills, assistance in learning skills necessary for job retention.
2. Assisting a beneficiary to develop and operate a micro-enterprise. This assistance consists of:
 - a. Aiding the beneficiary to identify potential business opportunities;
 - b. Assistance in the development of a business plan, including potential sources of business financing and other assistance; and
 - c. Identification of the supports that are necessary in order for the beneficiary to operate the business.
3. Coaching and employment support activities that enable a beneficiary to complete initial job training or maintain employment such as monitoring, supervision, assistance in job tasks, work adjustment training and counseling.

Long term follow-up supports include:

1. Coaching and employment support activities that enable a beneficiary to maintain employment in a group such as an enclave or mobile crew;
2. Ongoing assistance, counseling and guidance for a beneficiary who operates a microenterprise once the business has been launched;
3. Assisting the beneficiary to maintain employment through activities such as monitoring, supervision, assistance in job tasks, work adjustment training and counseling; and
4. Employer consultation with the objective of identifying work related needs of the beneficiary and proactively engaging in supportive activities to address the problem or need.

Documentation will be maintained in the file of each provider agency, Employer of Record or Agency With Choice specifying that this service is not otherwise available under a program funded under Section 110 of the Rehabilitation Act of 1973, or Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.) for this beneficiary. The provider agency, Employer of Record or Agency With Choice is responsible for obtaining this documentation.

The service includes transportation from the beneficiary's residence and to and from the Job site. The provider agency's payment for transportation from the beneficiary's residence and the beneficiary's job site is authorized service time.

Exclusions	<p>FFP is not to be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:</p> <ol style="list-style-type: none"> 1. Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program; 2. Payments that are passed through to users of supported employment programs; or 3. Payments for training that are not directly related to a beneficiary's supported employment program.
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	<p>While it is not prohibited to both employ a beneficiary and provide service to that same beneficiary, the use of Medicaid funds to pay for Supported Employment Services to providers that are subsidizing their participation in providing this service is improper. The following types of situations are indicative of a provider subsidizing its participation in supported employment:</p> <ol style="list-style-type: none"> 1. The job/position would not exist if the provider agency was not being paid to provide the service. 2. The job/position would end if the beneficiary chose a different provider agency to provide service. 3. The hours of employment have a one to one correlation with the amount of hours of service that are authorized. <p>For beneficiaries who are eligible for educational services under the Individuals With Disability Educational Act, personal care does not include transportation to/from school settings. This includes transportation to/from the beneficiary's home, provider home where the beneficiary may be receiving services before or after school or any other community location where the beneficiary may be receiving services before or after school.</p> <p>Supported Employment services occur in integrated environments with non-disabled individuals or is a business owned by the beneficiary.</p> <p>Supported Employment services do not occur in licensed community day programs.</p> <p>This service is not available at the same time of day as Community Networking, Day Supports, In-Home Intensive Services, In- Home Skill Building, Personal Care Services Residential Supports, Respite or one of the State Plan Medicaid services that works directly with the person.</p>		
Limits on amount, frequency, or duration	The amount of Supported Employment Services is subject to the limitation on the number of hours of services. The amount of Supported Employment Services is also subject to the amount of person's Support Needs Category Budget if currently phased into the Support Needs Matrix 8.		
Service Delivery Method	<ul style="list-style-type: none"> ■ Provider Directed ■ Individual/Family Directed 		
Provider Type	License	Certification	Other Standard
Employee in a beneficiary-directed arrangement		NC G.S. 122 C, as applicable	<p>Staff that work with beneficiaries are approved by employer of record or recommended by Managing Employer and approved by Agency with Choice</p> <p>If providing transportation, have a valid North Carolina or other valid driver's license, a safe driving record and an acceptable level of automobile liability insurance</p> <p>Criminal background check presents no health and safety risk to beneficiary</p> <p>Are at least 18 years old</p>

			<p>Not listed in the North Carolina Health Care Abuse Registry</p> <p>Qualified in CPR and First Aid</p> <p>Qualified in the customized needs of the beneficiary as described in the ISP</p> <p>Staff that work with beneficiaries must have a high school diploma or high school equivalency (GED)</p> <p>Persons who do not have three years of experience and were employed at the implementation of this waiver may continue to provide supported employment to the same beneficiary Grandfathering applies to staff employed by a provider agency providing authorized Supported Employment or Long Term Vocational Supports at the time the PIHP and beneficiary transition to NC Innovations.</p> <p>Supervised by the employer of record or managing employer</p> <p>For service directed by the Agency with Choice, paraprofessionals providing this service must be supervised by a qualified professional. Supervision must be provided according to supervision requirements specified in 10A NCAC 27G.0204 (b) (c) (f) and according to licensure or certification requirements of the appropriate discipline.</p> <p>State Nursing Board Regulations must be followed for tasks that present health and safety risks to the beneficiary as directed by the PIHP Medical Director or Assistant Medical Director</p> <p>Agencies with Choice follow State Nursing Board Regulations</p> <p>Upon enrollment with the PIHP, the Agency with Choice must have achieved national accreditation with at least one of the designated accrediting agencies.</p> <p>The Agency with Choice must be established as a legally constituted entity capable of meeting all of the requirements of the PIHP.</p> <p>Competencies as specified by the DMA. .</p>
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<p>Provider Agencies</p>		<p>NC G.S. 122 C,</p>	<p>Approved as a vendor in the PIHP provider network</p> <p>Agency staff that work with beneficiaries: Are at least 18 years old</p> <p>If providing transportation, have a valid North Carolina or other valid driver's license, a safe driving record and an acceptable level of automobile liability insurance</p> <p>Criminal background check presents no health and safety risk to beneficiary</p> <p>Not listed in the North Carolina Health Care Abuse Registry.</p> <p>Qualified in CPR and First Aid</p> <p>Staff that work with beneficiaries must be qualified in the customized needs of the beneficiary as described in the ISP.</p> <p>Staff that work with beneficiaries must have a high school diploma or high school equivalency (GED)</p> <p>Persons who do not have three years of experience and were employed at the implementation of this waiver may continue to provide supported employment to the same beneficiary).</p> <p>Grandfathering applies to staff employed by a provider agency providing authorized Supported Employment or Long Term Vocational Supports at the time the PIHP and beneficiary transition to NC Innovations.</p> <p>Paraprofessionals providing this service must be supervised by a qualified professional. Supervision must be provided according to supervision requirements specified in 10A NCAC 27G.0204(b) (c) (f) and according to licensure or certification requirements of the appropriate discipline.</p> <p>Upon enrollment with the PIHP, the organization must have achieved national accreditation with at least one of the designated accrediting agencies.</p> <p>The organization must be established as a legally constituted entity capable of meeting all of the</p>
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			requirements of the PIHP. Competencies as specified by the DMA.
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Vehicle Modifications: T2039

Vehicle Modifications are devices, service or controls that enable beneficiaries to increase their independence or physical safety by enabling their safe transport in and around the community. The installation, repair, maintenance, and training in the care and use of these items are included. The waiver beneficiary or his/her family must own or lease the vehicle. The vehicle must be covered under an automobile insurance policy that provides coverage sufficient to replace the adaptation in the event of an accident. Modifications do not include the cost of the vehicle or lease. There must be a written recommendation by an appropriate professional that the modification will meet the needs of the beneficiary. All items must meet applicable standards of manufacture, design, and installation. Installation must be performed by the adaptive equipment manufacturer's authorized dealer according to the manufacturer's installation instructions, National Mobility Equipment Dealer's Association, Society of Automotive Engineers, National Highway and/or Traffic Safety Administration guidelines. A physician's signature certifying medical necessity shall be included with the written request for Vehicle Modifications.

Repair of equipment is covered for items purchased through the waiver or purchased prior to waiver participation, as long as the item is identified within this service definition and the cost of the repair does not exceed the cost of purchasing a replacement piece of equipment.

Covered Modifications are:

1. Door handle replacements
2. Door modifications
3. Installation of raised roof or related alterations to existing raised roof system to approve head clearance
4. Lifting devices
5. Devices for securing wheelchairs or scooters
6. Adapted steering, acceleration, signaling, and breaking devices only when recommended by a physician and a certified driving evaluator for people with disabilities, and when training in the installed device is provided by certified personnel
7. Handrails and grab bars
8. Seating modifications
9. Lowering of the floor of the vehicle

Exclusions	<ol style="list-style-type: none"> 1. Vehicle Modifications are not available to beneficiaries who receive Residential Supports or who live in licensed residential facilities. 2. The cost of renting/leasing a vehicle with adaptations; service and maintenance contracts and extended warranties; and adaptations purchased for exclusive use at the school/home school are not covered. 3. Items that are not of direct or remedial benefit to the beneficiary are excluded from this service.
Limits on amount, frequency, or duration	The service is limited to expenditures of \$20,000 over the duration of the waiver.
Service Delivery Method	<input checked="" type="checkbox"/> Provider Directed <input type="checkbox"/> Individual/Family Directed

Provider Type	License	Certification	Other Standard
Specialized Vendors	Applicable state/local business license		Meets applicable state and local requirements for type of device that the vendor is providing
Commercial/Retail Businesses	Applicable state/local business license		Meets applicable state and local requirements for type of device that the vendor is providing

Attachment D: Limits on Sets of Services

The following limits apply:

- a. Adult beneficiaries (ages 21 years and older) who receive residential supports: No more than 40 hours per week is authorized for any combination of community networking, day supports and supported employment services.
- b. Child beneficiaries (through age 20) who receive residential supports: during the school year, no more than 20 hours per week is authorized for any combination of community networking, day supports and supported employment services. When school is not in session, up to 40 hours per week may be authorized.
- c. Adult beneficiaries who live in private homes: No more than 84 hours per week is authorized for any combination of community networking, day supports, supported employment, personal care and/or in-home skill building.
- d. Child beneficiaries who live in private homes: During the school year, no more than 54 hours per week is authorized for any combination of community networking, day supports, supported employment, personal care and in-home skill building. When school is not in session, up to 84 hours per week may be authorized.

Adult and child beneficiaries who live in private homes with intensive support needs: These beneficiaries may receive up to an additional 12 hours per day in-home intensive supports to allow for 24 hours per day of support with the prior approval of the PIHP. For all services in the above sets of services in, **a** through **d**, if a beneficiary is getting only one service out of the set of services subject to a limit, the limit is applied to the one service received.

Attachment E: The Supports Intensity Scale (SIS) ®

All NC Innovations waiver beneficiaries must have their support needs evaluated through the Supports Intensity Scale (SIS®). The SIS is a nationally recognized assessment developed by the American Association of Intellectual and Developmental Disabilities (AAIDD). Refer to the following website for more information on the AAIDD - <http://www.aaidd.org>.

The SIS is conducted in an interview format by an AAIDD trained and certified SIS Interviewer. The assessment is completed using the following two age based tools:

1. For beneficiaries 16 years of age and older, the Supports Intensity Scale for Adults is utilized,
2. For beneficiaries ages 5 through 15, the Supports Intensity Scale for Children is utilized.

Beneficiaries who are new to the NC Innovations waiver will receive a SIS prior to their initial NC Innovations waiver plan. Beneficiaries who transitioned to NC Innovations from the CAP-IDD waiver will receive a SIS within the first two years of their participation in NC Innovations.

Re-evaluation will occur every two years for beneficiaries ages 5-15 years of age and every three years for beneficiaries 16 years of age and older.

Re-evaluation may occur when the beneficiary experiences a major life change. This means a change in the health and/or safety of a beneficiary that merits examination of the types of supports that may be needed by the beneficiary. A major life change may trigger the need to conduct a new SIS prior to the regularly scheduled re-assessment date. This may include, but is not limited to:

1. An emergency/crisis in the beneficiary's living situation, including loss of the current living situation;
2. Repeated incidents relating to the beneficiary's or other persons' health and safety; and
3. A new diagnosis of a serious mental health condition; or development of new co-morbid conditions.

Re-evaluation may also occur when the beneficiary or legally responsible person disagrees with the original score. If a beneficiary/legally responsible person has questions or concerns about the SIS results, the following process occurs:

1. The beneficiary/legally responsible person contacts the LME/MCO within 10 days of receipt of the SIS score.
2. Within three (3) business days of notifying the LME/MCO of questions/concerns, the SIS Interviewer will contact the beneficiary/legally responsible person (requester) by phone to review the SIS summary and answer any questions. At the conclusion of this call, the SIS Interviewer will specifically ask if the beneficiary/legally responsible person would like to meet to further discuss the results and possibly request a new SIS.
3. If the beneficiary/legally responsible person expresses a desire to meet and/or requests a new SIS, the SIS Interviewer will meet with the beneficiary/legally responsible person face-to-face within two (2) weeks, ensuring that a second SIS Interviewer or care coordinator is present at this meeting.
4. At the face-to-face meeting with the beneficiary/legally responsible person, the SIS Interviewer will review the SIS raw data and provide needed interpretation. The SIS Interviewer will provide a copy of the raw data to the beneficiary/legally responsible person only after meeting with them to review and provide interpretation. The raw data for the SIS will not be released until this occurs.
5. Requests for a new SIS will be scheduled within thirty (30) days of the request and a new SIS will be administered at that time. Additionally, the second SIS assessment should be conducted by a different SIS Interviewer whenever possible.

Note: The SIS Interviewer will document all contacts, telephone or face-to-face, with the beneficiary/legally responsible person related to the SIS.

Attachment F: Relative as Provider

This policy applies to waiver participants ages 18 and older who live with a relative or legal guardian who is employed by a waiver provider agency.

Relatives are defined as individuals related by blood or marriage to the waiver participant. The relative must live in the home of the waiver participant. Excluded from this policy are the following relatives: biological or adoptive parents of a minor child, stepparents of a minor child or the spouse of a waiver participant.

Residential Supports may not be provided by parents, step parents or adoptive parents of adult participants or by other individuals residing in the adult individual's natural home.

Employers of Record and Managing Employers participating in the Individual Family Directed option may not be employed to provide waiver services.

The waiver services that may be provided under this policy are:

1. In-home skill building;
2. In-home intensive supports;
3. Residential supports; and
4. Personal care.

It is recommended that relatives residing in the home of the recipient provide no more than 40 hours per week of services to the person. If additional hours are requested to be provided by relatives residing in the home of the recipient then justification needs to be provided as to why other providers are not available and assurances of provider choice and that the individual will not be isolated from their community.

The PIHP ensures compliance with the conditions of this policy through a prior approval process. The PIHP provides an increased level of monitoring for services delivered by relatives/legal guardians. Services delivered by relatives/legal guardians are monitored monthly. Care Coordinators monitor through on-site monitoring and documentation review to ensure that payment is made only for services rendered and that the services are furnished in the best interest of the individual.

The ISP contains documentation that the waiver participant is in agreement with the employment of the relative and has been given the opportunity to fully consider all options for employment of non-related staff for waiver service provision.

The relative or legal guardian will not be reimbursed for any activity that they would ordinarily perform or are responsible to perform.

Provider agencies, Employers of Record and Agency with Choice in conjunction with the Managing Employer monitor the relative or legal guardian's provision of the service, on site a minimum of one time per month.